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MEMORANDUM

TO: HEALTH AND HUMAN SERVICES TASK FORCE MEMBERS
FROM: SEAN RILEY, DIRECTOR, HEALTH AND HUMAN SERVICES TASK FORCE
RE: 35-DAY MAILING—ALEC'S STATES AND NATION POLICY SUMMIT
DATE: OCTOBER 30, 2013

The American Legislative Exchange Council will host its States and Nation Policy Summit December 4-6 at the Grand Hyatt Washington in Washington, D.C. If you have not yet registered, the States and Nation Policy Summit agenda, registration, and hotel information are available online. Please note that the housing cut-off deadline is November 6.

The Scope of Practice Working Group will meet on Wednesday, December 4 from 10:00 to 11:00 a.m. All Task Force members are welcome to attend, and those interested in taking part should contact HHS Legislative Analyst, Ed Walton, at ewalton@alec.org, for additional information.

The Health and Human Services Task Force meeting will take place on Thursday, December 5th from 2:30 to 5:30 p.m.

Additionally, please find the following HHS briefing materials enclosed:

- Faxable registration form for the ALEC States and Nation Policy Summit
- Agenda for the ALEC States and Nation Policy Summit
- Tentative Agenda for the HHS Task Force Meeting
- Proposed Model Legislation for consideration
- Sunset Review materials
- ALEC Mission Statement

As a reminder, the attached is not official ALEC model policy until it passes both the HHS Task Force and the ALEC National Board of Directors.

I look forward to seeing you all in Washington, D.C. for what is sure to be a constructive meeting. If you have any questions or feedback on proposed model legislation, please do not hesitate to contact me at (202) 309-1274, or at sriley@alec.org.

Best regards,

Sean Riley
Director, Health and Human Services Task Force
American Legislative Exchange Council

2013 ALEC STATES & NATION POLICY SUMMIT

December 4 – 6, 2013

Grand Hyatt Washington
1000 H Street, NW • Washington, D.C. 20001

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ATTENDEE REGISTRATION / HOUSING FORM

Early registration deadline: November 6, 2013
Housing cut-off date: November 6, 2013

Online www.alec.org **Email** meetings@alec.org **Fax** 703.373.0932 **Phone / Questions** 571.482.5056 (Mon-Fri, 9am-5pm EST)

ATTENDEE INFORMATION

Prefix _____ First Name _____ Middle Initial _____ Last Name _____ Suffix(s) : _____
Badge Nickname: _____ Title _____
Organization *(required)* _____
Preferred Mailing Address: ☐ Business ☐ Home _____
City _____ State/Province _____ Country _____ ZIP/Postal code _____
Preferred Phone ☐ Work ☐ Home ☐ Mobile _____ Alternate phone ☐ Work ☐ Home ☐ Mobile _____ Fax _____
Email *(confirmation will be sent by email)* _____
On-site Emergency Information Name of Person to Contact: _____ Phone _____ Relationship to You: _____
Do you have any special physical, dietary (for example, vegetarian, kosher), or other needs: ☐ Yes ☐ No
If yes, please describe: _____
☐ This is my first time attending an ALEC event.

***Spouse / Guest:** If registering a spouse or guest, please complete the spouse/guest registration form. Spouse / guest registration is meant to accommodate legal spouses and immediate family members. Attendees from the same organization must register independently.

REGISTRATION INFORMATION

*** Please note that member fees are subject to verification*	*EARLY until Nov6*	*ON-SITE begin Nov 6*	*DAILY*
☐ ALEC Legislative Member	$375	$475	$300
☐ Legislator / Non-Member	$475	$575	$400
☐ ALEC Private Sector Member	$650	$750	$445
☐ Private Sector / Non-Member	$925	$1100	$545
☐ ALEC Non-Profit Member (501(c)(3) status required)	$525	$625	$400
☐ Non-Profit Non-Member (501(c)(3) status required)	$675	$825	$500
☐ Legislative Staff / Government	$375	$475	$300
☐ ALEC Alumni	$425	$525	$300
☐ ALEC Legacy Member	$0	$0	$0

For Daily Registration, select which day: ☐ Wed ☐ Thur ☐ Fri

METHOD OF REGISTRATION PAYMENT

Credit Card: Credit cards will be charged immediately.
☐ Amer Express ☐ Visa ☐ MasterCard
Card # _____
Cardholder *(please print)* _____
Exp Date *(mm/yy)* _____ Security Code_____
Signature _____

REGISTRATION FEES: $ _____

Note: Registration forms with enclosed payments must be received by November 6, 2013 to be eligible for early bird registration rates. Forms and/or payments received after November 6, 2013 will be subject to the on-site registration rate.

REGISTRATION CONFIRMATION INFORMATION

Online registrants will receive immediate email confirmation. If registering by form, confirmation will be emailed, faxed, or mailed within 72 hours of receipt of payment.

REGISTRATION CANCELLATION / REFUND INFORMATION

Registrations cancelled prior to 5pm EST November 6, 2013 are subject to a $100 cancellation fee. Registrations are non-refundable after 5pm EST November 6, 2013.

HOUSING — RESERVATION CUTOFF FOR ALEC DISCOUNTED RATE IS November 6, 2013

Grand Hyatt Washington **Arrival Date** _____ **Departure Date** _____

Sharing with: (Maximum 4 guests per room)
_____

Room Type		
□ Single	(1 person – 1 bed)	$289
□ Double	(2 persons – 1 bed)	$289
□ Double/ Double	(2 persons – 2 beds)	$289
□ Triple	(3 persons – 2 beds)	$314
□ Quad	(4 persons – 2 beds)	$314

Special requests
☐ ADA room required:
___ Audio ___ Visual ___ Mobile
☐ Rollaway / crib: _____
☐ Other: _____
_____

All rates DO NOT include state and local tax currently *14.5% (subject to change)*

Credit Card Information/ Reservation Guarantee

Credit Card information is required at time of reservation to guarantee the reservation. Card must be valid through December 2013

☐ Please use the same credit card information as above.
☐ Amer Express ☐ Visa ☐ MasterCard ☐ Discover
Card # _____
Cardholder *(please print)* _____
Exp Date *(mm/yy)* _____ Security Code_____
Signature _____

Note: Cutoff for reservations at the ALEC rate is November 6, 2013. After November 6, 2013, every effort will be made to accommodate new reservations, based on availability and rate. Room types and special requests are not guaranteed. The hotel will assign specific room types at check in, based upon availability.

HOUSING CONFIRMATION INFORMATION

Online reservations will receive immediate email confirmation. Reservations received by form will be confirmed via email, fax, or mail within 72 hours of receipt.

HOUSING CANCELLATION / REFUND INFORMATION

Credit cards will be charged one night room and tax in the event of a no show or if cancellation occurs within 72 hours prior to arrival. Early departure fee is one night's room and taxPlease obtain a cancellation number when your reservation is cancelled.

2013 ALEC STATES & NATION POLICY SUMMIT

December 4 – 6, 2013

Grand Hyatt Washington
1000 H Street, NW ● Washington, D.C. 20001

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SPOUSE/GUEST REGISTRATION FORM

Online www.alec.org | **Fax** (*credit cards only*) 703.373.0932 | **Phone / Questions** ● Mon-Fri, 9am-5:00 pm EST 571.482.5056

ATTENDEE INFORMATION IS REQUIRED TO REGISTER A SPOUSE OR GUEST

First Name _____ Last Name _____

Organization _____

Daytime phone _____

Email (*Confirmation will be sent by email*) _____

SPOUSE / GUEST REGISTRATION

SPOUSE / GUEST REGISTRATION GUIDELINES

1. Spouse / guest registration is meant to accommodate legal spouse and immediate family members.
2. Attendees from the same organization must register independently. No exception will be made.
3. Spouse / guest designation will be clearly visible on name badge.

Prefix _____ Last Name _____ First Name _____ Middle initial _____ Badge Nickname _____

Prefix _____ Last Name _____ First Name _____ Middle initial _____ Badge Nickname _____

Prefix _____ Last Name _____ First Name _____ Middle initial _____ Badge Nickname _____

SPOUSE / GUEST REGISTRATION FEES	***Number of Spouse/Guest(s)***	***Fee***	***TOTAL***
□ Spouse / Guest *please note name(s) above*	_____	$ 150	$ _____

METHOD OF SPOUSE / GUEST REGISTRATION PAYMENT

Credit Card: Credit cards will be charged immediately. Please fax to the above number for processing.

□ Amer Express
□ Visa
□ MasterCard

Card # _____

Cardholder (*please print*) _____

Exp Date (*mm/yy*) _____/_____ Signature _____

REGISTRATION CONFIRMATION INFORMATION

Online registrants will receive immediate email confirmation. If registering by form, confirmation will be emailed within 72 hours of receipt of payment.

REGISTRATION CANCELLATION / REFUND INFORMATION

Registrations cancelled prior to 5pm EST November 6, 2013 are subject to a $100 cancellation fee. Registrations are non-refundable after 5pm EST November 6, 2013.

Date & Time	Program
Tuesday, December 3	
9:00am - 5:00pm	Joint Board of Directors Meeting
1:00pm - 6:00pm	**Registration**
2:00pm - 6:00pm	Exhibitor Set Up
6:00pm - 9:00pm	Board of Directors Receptions and Dinner

Date & Time	Program
Wednesday, December 4	
7:00am - 6:00pm	**Registration**
7:00am - 9:00am	Exhibitor Set Up
7:30am - 11:30am	Subcommittee Meetings (Check with Task Force Director)
9:00 - 5:00pm	**ALEC Exhibition Hall Open**
9:00am - 11:00am	State Chairs Meeting
11:30am - 1:15pm	**Opening Luncheon (Speaker TBA)**
1:30pm - 2:45pm	Workshops (Topics TBA)
3:00pm - 4:15pm	Workshops (Topics TBA)
5:30pm - 6:30pm	**Jefferson Reception**

Date & Time	Program
Thursday, December 5	
7:00am - 7:00pm	**Registration**
8:00am - 9:15am	**Plenary Breakfast (Speakers TBA)**
9:30am - 5:00pm	ALEC Exhibition Hall Open
9:30am - 10:45am	Workshops (Topics TBA)
11:00am - 12:15pm	Workshops (Topics TBA)
12:30pm - 2:15pm	**Plenary Lunch (Speakers TBA)**
2:30pm - 5:30pm	Justice Performance Project
2:30pm - 5:30pm	Health and Human Services Task Force Meeting
2:30pm - 5:30pm	Tax and Fiscal Policy Task Force Meeting
2:30pm - 5:30pm	International Relations Task Force Meeting
6:00pm - 7:00pm	**Reception**

Date & Time	Program
Friday, December 6	
7:30am - 3:00pm	**Registration**
8:00am - 9:15am	**Plenary Breakfast (Speakers TBA)**
9:30am - 2:00pm	ALEC Exhibition Hall Open
9:30am - 10:45am	Workshops (Topics TBA)
11:00am - 12:15pm	Workshops (Topics TBA)
12:30pm - 2:15pm	**Plenary Lunch (Speakers TBA)**
2:30pm - 5:30pm	Civil Justice Task Force Meeting
2:30pm - 5:30pm	Commerce, Insurance and Economic Development Task Force Meeting
2:30pm - 5:30pm	Communications and Technology Task Force Meeting
2:30pm - 5:30pm	Education Task Force Meeting
2:30pm - 5:30pm	Energy, Environment, and Agriculture Task Force Meeting
2:00pm - 5:00pm	Exhibitor Load Out
6:00pm - 7:00pm	**Reception**
7:00pm-11:00pm	State Night (Contact Your State Chair)

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Health and Human Services Task Force Meeting | States and Nation Policy Summit
Thursday, December 5, 2013
2:30 - 5:30 p.m.

TENTATIVE AGENDA

2:30 p.m. CALL TO ORDER

Welcoming Remarks
Senator Judson Hill, Georgia, HHS Public Sector Chair
Marianne Eterno, Guarantee Trust Life Insurance, HHS Private Sector Chair

Introduction of Task Force Members and Guests
Approval of Minutes

2:45 p.m. SPECIAL PRESENTATIONS

An Update on Outstanding ACA Lawsuits
Exploring Access to Investigational Medication
Health Exchange Implementation
Medicaid Expansion and Enrollment Trends
Are Exchanges Worth the Risk?

3:30 p.m. PROPOSED MODEL LEGISLATION: DISCUSSION AND VOTING

Health Professional Modernization Act
Medicaid Block Grant Act
Medical Consultation Act
Navigator Background Check Act
Oral Health Standards Act
Patient Access Expansion Act

5:00 p.m. SUNSET REVIEW

5:30 p.m. GOOD OF THE ORDER/ADJOURNMENT

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Proposed Model Legislation

Health and Human Services Task Force

Health Professional Modernization Act

Medicaid Block Grant Act

Medical Consultation Act

Navigator Background Check Act

Oral Health Standards Act

Patient Access Expansion Act

Health Professional Modernization Act
(DRAFT, December 5, 2013)

Section 1. Short Title. This Act shall be known as the "Health Professional Modernization Act."

Section 2. Definitions.

A. In this Act, "advanced practice registered nurse" means a nurse practitioner, nurse anesthetist, nurse-midwife, or clinical nurse specialist who holds a license issued under **{insert state licensing statute}** and who:

1. Has successfully completed a graduate-level advanced practice registered nursing education program accredited by a national accrediting organization recognized by the respective board that prepares the nurse to function as a nurse practitioner, nurse anesthetist, nurse-midwife, or clinical nurse specialist;

2. If the education program required under Paragraph 1 was completed after January 1, 1996, has met requirements established or recognized by the respective board for national certification;

3. Is licensed by the respective board to provide nursing care in an area with a targeted population group recognized and approved by the respective board; and

4. Meets requirements established by the respective board for continued competence.

B. The term "advanced practice registered nurse" is synonymous with "advanced nurse practitioner" and "advanced practice nurse".

Section 3. Scope of Practice.

A. Primary care by an advanced practice registered nurse is based on:

1. Knowledge and skills acquired in basic nursing education;

2. Licensure as a registered nurse;

3. Successful completion of a graduate-level advanced practice registered nursing program accredited by a national accrediting organization recognized by the respective board;

4. Current certification in accordance with **{insert reference to state occupations code or similar chapter}** by a national certifying body recognized by the respective board in the appropriate advanced practice registered nursing role approved by the respective board; and

5. Nursing care provided in an area with at least one targeted population group recognized and approved by the respective board.

B. Practice as an advanced practice registered nurse is an expanded scope of nursing practice in a role approved by the respective board and in an area with a targeted population group

recognized and approved by the respective board, with or without compensation or other personal profit, and includes the scope of practice of a registered nurse.

C. The scope of practice of an advanced practice registered nurse includes, but is not limited to, advanced assessment, diagnosing, prescribing, and ordering.

D. An advanced practice registered nurses may serve as a primary care provider of record.

Section 4. Applicability to Primary Care Providers.

A. This Act does not limit or modify the scope of practice of a registered nurse who is not an advanced practice registered nurse approved by the board.

B. The scope of practice of a registered nurse includes any act of professional nursing the nurse is authorized to perform under this Act.

Section 5. Licensure. A person may not practice or offer to practice advanced practice registered nursing in this state unless the person is licensed as an advanced practice registered nurse under this Act.

Section 6. Application. An applicant for an advanced practice registered nurse license shall submit to the respective board an application on the form prescribed by the respective board, any required fee, and any other information required by the respective board.

Section 7. Practice by Primary Care Provider.

A. An advanced practice registered nurse who holds a license issued under this Act may:

1. Diagnose, prescribe, and institute therapy or referrals of patients to health care agencies, health care providers, and community resources; and

2. Plan and initiate a therapeutic regimen that includes ordering and prescribing medical devices and equipment, nutrition, and diagnostic and supportive services, including home health care, hospice, physical therapy, and occupational therapy.

B. An advanced practice registered nurse shall practice as a licensed independent practitioner in accordance with standards established and recognized by the respective board to protect the public health and safety.

C. An advanced practice registered nurse is accountable to patients, the nursing profession, and the respective board for:

1. Complying with the requirements of this Act;

2. Providing quality advanced nursing care;

3. Recognizing the nurse's limits of knowledge and experience;

4. Planning for the management of situations beyond the nurse's expertise; and

5. Consulting with or referring patients to other health care providers as appropriate.

Section 8. Prescribing and Ordering Authority.

A. The respective board may grant prescribing and ordering authority in accordance with this Act through the issuance of an advanced practice registered nursing license to a registered nurse approved by the respective board to practice as an advanced practice registered nurse.

B. As authorized by the respective board, an advanced practice registered nurse may prescribe, procure, administer, and dispense dangerous drugs and controlled substances.

Section 9. Notwithstanding **{insert section of state occupations code}**, as added by this Act, an advanced practice registered nurse who has been approved by the respective board to provide advanced nursing care is not required to hold a license as an advanced practice registered nurse until **{insert date}**.

Section 10. {Severability Clause}

Section 11. {Repealer Clause}

Section 12. {Effective Date}

Medicaid Block Grant Act
(DRAFT, December 5, 2013)

Summary

This Act relates to reforms designed to support state Medicaid programs, including requesting federal authorization to fund the state Medicaid program through a block grant or similar funding.

Model Legislation

Chapter 1. Title and Definitions.

Section 1. Title. This Act shall be known as the "Medicaid Block Grant Act."

Section 2. Definitions.
In this Act:

(1) "Commission" means **{insert applicable state health and human services agency or commission}**.

(2) "Health benefit exchange" means an American Health Benefit Exchange administered by the federal government or an exchange created under Section 1311(b) of the Patient Protection and Affordable Care Act (42 U.S.C. § 18031(b)).

(3) "Long-term care services" means the provision of personal care and assistance related to health and social services given episodically or over a sustained period to assist individuals of all ages and their families to achieve the highest level of functioning possible, regardless of the setting in which the assistance is given.

(4) "Medicaid program" means the medical assistance program established and operated under Title XIX, Social Security Act (42 U.S.C. § 1396 et seq.).

(5) Nursing facility" means a convalescent or nursing home or related institution licensed under **{insert state nursing home licensing provision}**, that provides long-term care services to medical assistance recipients.

(6) "Patient Protection and Affordable Care Act" means the federal Patient Protection and Affordable Care Act (Pub. L. No. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152).

(7) "State Medicaid program" means the medical assistance program provided by this state under the Medicaid program.

(8) "State supported living center" means a state-supported and structured residential facility operated by the **{insert state Department of Aging and Disability Services or comparable department}** to provide to clients with mental retardation a variety of services, including medical treatment, specialized therapy, and training in the acquisition of personal, social, and vocational skills.

(9) "Task force" means the Medicaid Reform Task Force established under Chapter 6 of this Act.

Chapter 2. Federal Authorization to Reform State Medicaid Program; General Provisions.

Section 1. Federal Authorization to Reform Medicaid Required.

If the federal government establishes, through conversion or otherwise, a block grant funding system for the Medicaid program or otherwise authorizes the state Medicaid program to operate under a block grant funding system, including under a Medicaid program waiver, the commission, in cooperation with applicable health and human services agencies, shall, subject to Section 3 of this Chapter, administer and operate the state Medicaid program in accordance with Chapters 2-4 of this Act.

Section 2. Conflict With Other Law.

To the extent of a conflict between a provision of Chapters 2-4 and:

(1) another provision of state law, the provision of Chapters 2-4 controls; and

(2) a provision of federal law or any authorization described under Section (1) of this chapter, the federal law or authorization controls.

Section 3. Establishment of Reformed State Medicaid Program.

The commission shall establish a state Medicaid program that provides benefits under a risk-based Medicaid managed care model.

Section 4. Rules.

The executive commissioner shall adopt rules necessary to implement Chapters 2-4.

Chapter 3. Acute Care.

Section 1. Eligibility for Medicaid Acute Care.

(A) An individual is eligible to receive acute care benefits under the state Medicaid program if the individual:

(1) meets the eligibility requirements that were in effect immediately before implementation of the block grant funding system described by Chapter 2, Section 1; or

(2) is under 19 years of age and:

(a) is receiving Supplemental Security Income (SSI) under 42 U.S.C. § 1381 et seq.; or

(b) is in foster care or resides in another residential care setting under the conservatorship of **{insert applicable state protective services agency}.**

(B) The commission shall provide acute care benefits under the state Medicaid program to each individual eligible under this section through the most cost-effective means, as determined by the commission.

(C) If an individual is not eligible for the state Medicaid program under Subsection (A) and the individual's household income exceeds 100 percent of the federal poverty level, the commission shall refer the individual to a health benefit exchange.

Section 2. Medicaid Sliding Scale Subsidies.

(A) An individual who is eligible for the state Medicaid program under Section 1 of this Chapter may receive a Medicaid sliding scale subsidy to purchase a health benefit plan from an authorized health benefit plan issuer.

(B) A sliding scale subsidy provided to an individual under this section must:

(1) be based on:

(a) the average premium in the market; and

(b) a realistic assessment of the individual 's ability to pay a portion of the premium; and

(2) include an enhancement for individuals who choose a high deductible health plan with a health savings account.

(C) The commission shall ensure that counselors are made available to individuals receiving a subsidy to advise the individuals on selecting a health benefit plan that meets the individuals' needs.

(D) An individual receiving a subsidy under this section is responsible for paying:

(1) any difference between the premium costs associated with the purchase of a health benefit plan and the amount of the individual 's subsidy under this section; and

(2) any copayments associated with the health benefit plan.

(E) If the amount of a subsidy received by an individual under this section exceeds the premium costs associated with the individual 's purchase of a health benefit plan, the individual may deposit the excess amount in a health savings account that may be used only in the manner described by Section 3(C) of this Chapter.

Section 3. Delivery of Subsidies; Health Savings Accounts.

(A) The commission shall determine the most appropriate manner for delivering and administering subsidies provided under Section 2 of this Chapter or this section. In determining the most appropriate manner, the commission shall consider depositing subsidy amounts for an individual in a health savings account established for that individual.

(B) In addition to providing a subsidy to an individual under Section 2, the commission may provide additional subsidies for coinsurance payments, copayments, deductibles, and other cost-sharing requirements associated with the individual 's health benefit plan. The commission shall provide the additional subsidies on a sliding scale based on income.

(C) A health savings account established under this section may be used only to:

(1) pay health benefit plan premiums, copayments, and cost-sharing amounts;

(2) if appropriate, purchase health care-related goods and services; and

(3) pay administrative fees associated with providing the account.

Section 4. Medicaid Health Benefit Plan Issuers.

The commission shall allow any health benefit plan issuer authorized to write health benefit plans in this state to participate in the state Medicaid program.

Section 5. Maternity Benefits.

(A) To be eligible for purchase under the state Medicaid program, a health benefit plan must provide maternity benefits to state Medicaid program-eligible enrollees through an endorsement or rider adopted by the commissioner of insurance in consultation with the commission.

(B) Subject to Section 2 of this Chapter and other applicable requirements of Chapters 2-4, the state Medicaid program will pay to the health benefit plan issuer a premium in the amount fixed by the commissioner of insurance for the endorsement or rider. The commissioner of insurance shall set premium rates under this section in amounts that are based on sound actuarial principles and are not excessive, inadequate, unfairly discriminatory, or confiscatory as to the health benefit plan issuer.

(C) The commissioner of insurance by rule shall establish criteria for health benefit plans that provide maternity benefits under the state Medicaid program.

(D) The executive commissioner in consultation with the commissioner of insurance shall establish minimum criteria that a person must meet in order to be eligible to receive prenatal care under the state Medicaid program.

Section 6. Reinsurance for Participating Health Benefit Plan.

(A) The commission in consultation with the commissioner of insurance shall study a reinsurance program to reinsure participating health benefit plan issuers.

(B) In examining options for a reinsurance program, the commission and commissioner of insurance shall consider a plan design under which:

(1) a participating health benefit plan is not charged a premium for the reinsurance; and

(2) the health benefit plan issuer retains risk on a sliding scale.

Chapter 4. Long Term Care Services and Supports.

Section 1. Eligibility: Long Term Care Services and Supports.

(A) An individual is eligible to receive long-term care services and supports under the state Medicaid program if the individual:

(1) has a household income at or below 220 percent of the federal poverty level; or

(2) is under 19 years of age and:

(a) is receiving Supplemental Security Income (SSI) under 42 U.S.C. § 1381 et seq.; or

(b) is in foster care or resides in another residential care setting under the conservatorship of **{insert applicable state protective services agency}.**.

(B) In determining eligibility, the commission may consider resources in the manner specified by Section 4 of this Chapter.

Section 2. Delivery of Medicaid Benefits; Sliding Scale Subsidies.

(A) Except as provided by Section 6 of this Chapter, an individual who is eligible for long-term care benefits under the state Medicaid program shall receive a sliding scale subsidy in a predetermined amount to be used to purchase long-term care services and supports from authorized Medicaid providers.

(B) A sliding scale subsidy provided to an individual under this section must:

(1) be based on:

(a) a single estimate of the average cost per person of long-term care services and supports needed under the state Medicaid program; or

(b) multiple estimates of the average cost per person of long-term care services and supports needed under the state Medicaid program based on the populations to be served;

(2) increase or decrease, as appropriate, given budgetary considerations in accordance with Section 7 of this Chapter; and

(3) vary in amount granted to each individual based on the results of assessments required in accordance with Section 4 of this Chapter.

(C) An individual receiving a subsidy under this section is responsible for paying any difference between the cost of benefits and the amount of the individual's subsidy under this section.

(D) If the amount of a subsidy received by an individual under this section exceeds the amount needed to purchase long-term care services and supports benefits, the individual receiving the subsidy may deposit the excess amount in a health savings account that may be used only in the manner described by Section 3(B) of this Chapter.

Section 3. Delivery of Subsidies; Health Savings Accounts.

(A) The commission shall determine the most appropriate manner for delivering and administering subsidies provided under this Chapter. In determining the most appropriate manner, the commission shall consider depositing subsidy amounts for an individual in a health savings account established for that individual.

(B) A health savings account established under this section may be used only to:

(1) pay the cost of long-term care services and supports under the state Medicaid program; and

(2) if appropriate, purchase health care-related goods and services.

Section 4. Required Assessments.

(A) The commission shall establish a process for determining the amount of an eligible individual's subsidy under Section 2 of this Chapter that requires each individual eligible for benefits under the state Medicaid program to undergo:

(1) a disability and functional acuity assessment; and

(2) a financial assessment.

(B) The commission shall contract with an independent medical evaluator to perform the disability and functional acuity assessment required under Subsection (A)(1).

(C) In conducting the financial assessment required under Subsection (A)(2), the commission shall consider the resources available to the individual and the individual's family. The executive commissioner shall define "family" for purposes of this section.

(D) The commission shall use the results of both assessments required under this section to determine the amount of an eligible individual's subsidy.

Section 5. Authorized Providers.
The commission shall:

(1) establish standards for providers authorized to provide long-term care services and supports under the state Medicaid program; and

(2) make a list of authorized providers available to recipients under the program.

Section 6. Exemptions.
This Chapter does not apply to:

(1) an individual receiving medical assistance under the program of all-inclusive care for the elderly (PACE) established under **{insert state code provision establishing (PACE), if applicable}**.

(2) an individual who is eligible for benefits under the state Medicaid program and who requires placement in a nursing facility or state supported living center.

Section 7. Budgetary Considerations.

(A) To ensure that the state does not exceed the state's budget for the provision of the state Medicaid program, the commission shall:

(1) set maximum subsidy amounts allowed under this Chapter to increase or decrease at the same rate as federal and state funding; and

(2) implement measures to adjust spending as necessary to stay within budgeted amounts.

(B) Measures implemented under Subsection(A)(2) may include implementing uniform benefit reductions applied to all subsidy payments that are automatically triggered and enforced by the commission based on actual expenditures.

Chapter 5. Medicaid: Incremental Reform.

Section 1. Customized Benefits Package.

The commission shall, for individuals receiving home and community-based services instead of institutional long-term care services, develop and implement customized benefits packages that are designed to prevent the overutilization of services. Customized benefits packages under this section must be based on an individualized needs assessment administered at a single point of entry.

Section 2. Cost Effective Medicaid Managed Care Model.

Except as otherwise provided by this section and notwithstanding any other law, the commission shall provide medical assistance for acute care through the most cost-effective model of Medicaid managed care as determined by the commission. If the commission determines that it is more cost-effective, the commission may provide medical assistance for acute care in a certain part of this state or to a certain population of recipients using:

(1) a health maintenance organization model, including the acute care portion of Medicaid Star + Plus pilot programs; or

(2) a primary care case management model;

Section 3. Dual Eligible Integrated Care Demonstration Project.

(A) Subject to Subsection (B), the department shall establish a dual eligible integrated care demonstration project that would allow appropriate individuals described by **{insert state code provisions pertaining to dual Medicaid and Medicare coverage}**, as determined by the department, to receive long-term care services and supports under both the medical

assistance program and the Medicare program through a single managed care plan.

(B) An individual who is a resident of a state supported living center is exempt from participation in the demonstration project established under this section.

Section 4. Parental Fee Program.

(A) To the extent allowed by federal law, the department shall establish a parental fee program that requires the parent or legal guardian of a child receiving institutional long-term care services or home and community-based services under the medical assistance program established under this Chapter to pay a fee for those services. The fee imposed under this section must be greater for a parent or legal guardian of a child who receives institutional long-term care services.

(B) Failure to pay a fee under this section may not affect a child's eligibility for benefits under the medical assistance program, but the parent or legal guardian may be subjected to attempts by the department to collect the fee.

(C) The executive commissioner of the Health and Human Services Commission shall adopt rules necessary to implement this section.

Section 5. Filial Responsibility Requirement.

(A) To the extent allowed by federal law, the department shall require that each adult child of a recipient receiving institutional long-term care services or home and community-based services under the medical assistance program established under this Chapter assumes some financial responsibility for the care the adult child's parent receives by:

(1) assessing a fee against the adult child, imposed on a sliding scale based on the household income of the adult child; or

(2) imposing an assessment on any transfer made to the adult child in the five years preceding the date the parent-recipient was determined eligible for benefits.

(B) Failure by an adult child to pay a fee or assessment under this section may not affect the parent-recipient's eligibility for benefits under the medical assistance program, but the adult child may be subjected to attempts by the department to collect the fee.

(C) The executive commissioner of the Health and Human Services Commission shall adopt rules necessary to implement this section.

Section 6. Study and Report on Estate Recovery Program.

(A) **{Insert applicable state health and human services agency}** shall conduct a study to examine the estate recovery program implemented by this state under 42 U.S.C. § 1396p(b)(1) and determine options the state has to improve recovery under and increase the efficacy of the program.

(B) Not later than **{insert date}**, the commission shall submit a written report containing the findings of the study conducted under this section together with the commission's

recommendations to the governor, the lieutenant governor, and the standing committees of the senate and house of representatives having primary jurisdiction over the Medicaid program.

Section 7. Study and Report on Alternative Income and Asset Limits.

(A) **{Insert applicable state health and human services agency}**shall conduct a study imposing alternative income and asset limits for purposes of determining eligibility for long-term care services and supports under the medical assistance program under **{insert state code provisions for obtaining benefits for eligible citizens as authorized under the Social Security Act or any other federal act}**. The commission shall consider:

(1) imposing greater restrictions on exempt assets;

(2) limiting the amount of income that an individual may transfer into a qualified trust under 42 U.S.C. § 1396p(d)(4)(B) to an amount equal to the average cost of nursing home care; and

(3) reducing the income eligibility limit to qualify for Medicaid institutional long-term care or home and community-based waiver services under the medical assistance program under **{insert state code provisions for obtaining benefits for eligible citizens as authorized under the Social Security Act or any other federal act}**.

(B) Not later than **{insert date}**, the commission shall submit a written report containing the findings of the study conducted under this section together with the commission's recommendations to the governor, the lieutenant governor, and the standing committees of the senate and house of representatives having primary jurisdiction over the Medicaid program.

Section 8. Study and Report on Nursing Home Providers.

(A) **{Insert applicable state health and human services agency}** shall conduct a study on the feasibility of selecting and reimbursing nursing home providers under the medical assistance program under **{insert state code provisions for obtaining benefits for eligible citizens as authorized under the Social Security Act or any other federal act}**, using a competitive bidding process.

(B) Not later than **{insert date}**, the commission shall submit a written report containing the findings of the study conducted under this section together with the commission's recommendations to the governor, the lieutenant governor, and the standing committees of the senate and house of representatives having primary jurisdiction over the Medicaid program.

Chapter 6. Medicaid Reform Task Force.

Section 1. Task Force.

(A) The Medicaid Reform Task Force is established for purposes of advising the commission in designing a state Medicaid plan and program that are:

(1) consistent with Chapter 5 of this Act; and

(2) if the federal government establishes a block grant funding system in accordance with Chapter 2, Section 1 of this Act, consistent with Chapters 2-4 of this Act.

(B) The task force consists of 12 members appointed as follows:

(1) one member appointed by the governor;

(2) two members of **{insert appropriate state Senate body}** appointed by the lieutenant governor;

(3) two members of **{insert appropriate state house of representatives body}** appointed by the **{insert ranking member of state house of representatives body}**;

(4) one member from the **{insert Senate Committee on Finance or comparable committee}**, appointed by the presiding officer;

(5) one member from the **{insert House Appropriations Committee or comparable committee}**, appointed by the presiding officer;

(6) one member of **{insert Senate Committee on Health and Human Services or comparable committee}**, appointed by the presiding officer;

(7) one member of **{insert House Public Health Committee or comparable committee}**, appointed by the presiding officer;

(8) the executive commissioner of the commission or the executive commissioner's designee;

(9) one representative of **{insert Legislative Budget Board or comparable board}**; and

(10) one representative of the **{insert state Department of Insurance or comparable department}**.

(C) The governor shall appoint the presiding officer of the task force.

(D) A member of the task force serves without compensation.

(E) Not later than **{insert date}**, the appropriate appointing officers shall appoint the members of the task force.

(F) Not later than **{insert date}**, the task force shall submit a report to the legislature regarding its activities under this section.

(G) This section expires **{insert date}**.

Chapter 7. Federal Authorization, Effective Date, Severability, and Repeal.

Section 1. Federal Waiver or Authorization.

Before implementing any provision of this Act, other than Chapters 2-4 of this Act, **{insert applicable state health and human services agency or commission}** shall request any waiver or authorization from a federal agency that is necessary for implementation of that provision and shall delay implementing that provision until the waiver or authorization is granted.

Section 2. {Severability clause.}

Section 3. {Repealer clause.}

Section 4. {Effective date.}

Medical Consultation Act
(DRAFT, December 5, 2013)

Summary

This Act allows a patient to consult a second physician without first acquiring permission from the primary physician.

Model Legislation

Section 1. **Title.** This Act may be cited as the "Medical Consultation Act."

Section 2. Providing Consultations does not Constitute the Practice of Medicine. The act of conducting medical consultations for the purpose of providing a patient with a secondary assessment or opinion regarding any disease, condition, or any other health or medical defect supplementary to the assessment or opinion rendered by another health or medical professional shall not constitute the practice of medicine under **{insert applicable state law}**.

Section 3. Physician Permission Not Required. Notwithstanding any other law, no permission from any physician or other health or medical professional shall be required before a patient may receive a second assessment or opinion regarding any disease, condition, or any other health or medical defect.

Section 4. {Severability clause.}
Section 5. {Repealer clause.}
Section 6. {Effective date.}

Navigator Background Check Act
(DRAFT, December 5, 2013)

Summary

This Act creates registration and reporting procedures for health care insurance navigators.

Model Legislation

Section 1. Title. This Act shall be known as the "Navigator Background Check Act."

Section 2. Definitions.

"Health care insurance navigator" means a person who is selected to perform the activities and duties identified in 42 United States Code Section 18031(i) and includes any person who receives grant monies from the United States Department of Health and Human Services, state or a health care exchange or private monies to perform any of the activities or duties identified in 42 United States Code Section 18031(i).

Section 3. Health Care Insurance Navigator Registration and Reporting.

(A) A person shall not act as or hold himself out to be a health care insurance navigator unless that person registers with the **{insert state department of insurance}** and meets all of the following requirements:

(1) Submits application and registration fees in the amounts prescribed by the Department.

(2) Has received a high school diploma or general equivalency diploma.

(3) Successfully completes all federally required training programs.

(4) The **{insert state department of insurance}**shall submit a full set of fingerprints to the **{insert state department of public safety}** for the purpose of obtaining a state and federal criminal records check pursuant to **{insert relevant state criminal history records statute}** and Public Law 92-554. The **{insert state department of insurance}** shall not issue the registration if the person has been convicted of a felony offense or a misdemeanor offense involving fraud or dishonesty.

(B) The **{insert state department of insurance}** may deny, suspend or revoke the registration of a Health care insurance navigator if:

(1) The health care insurance navigator is charged with a felony offense.

(2) The health care insurance navigator is charged with a misdemeanor offense involving fraud or dishonesty.

(3) The **{insert state department of insurance}** receives credible reports that the Health care insurance navigator has provided false or fraudulent information to consumers.

(4) The health care insurance navigator has engaged in intentional or negligent conduct that has resulted in the release of a consumer's personally identifiable information.

(C) An organization employing a health care insurance navigator shall report to the **{insert state department of insurance}** any event that results in the unauthorized release of a consumer's personally identifiable information. The organization shall attempt to report this unauthorized release of personally identifiable information to the affected individual whose personal information was released within twenty-four hours after discovering the breach. The Department of Health and Human Services shall submit a report on or before February 1 of each year to the Speaker of the House of Representatives and the President of the Senate detailing the number of breaches reported to the **{insert state department of insurance}** pursuant to this subsection and the circumstances of each breach.

(D) Notwithstanding any other law, a health care insurance navigator shall not sell, solicit, or negotiate insurance for any class or classes of insurance when assisting individuals with enrollment or any other insurance navigator activities or duties through any health care exchange established or operating including any exchange established or operated by the United States Department of Health and Human Services.

(E) The **{insert state department of insurance}** shall maintain a website for the purpose of providing the public with a complete list of all currently registered health care insurance navigators.

Section 4. Current Health Care Insurance Navigators.

(A). A person who is acting as a health care insurance navigator pursuant to 42 United States Code section 18031 (i) on the effective date of this act shall register within ninety days after the effective date of this act with the **{insert state department of insurance}** pursuant to **{insert state law}** as added by this section, in order to continue performing the duties and activities of a Health care insurance navigator after the effective date of this act.

Section 5. {Severability clause.}
Section 6. {Repealer clause.}
Section 7. {Effective date.}

Oral Health Standards Act
(DRAFT, December 5, 2013)

Summary

This Act implements oral health instruction into public school curriculum.

Model Legislation

Section 1. Title. This Act shall be known as the "Oral Health Standards Act."

Section 2. Adoption of Oral Health Standards.

The **{insert applicable state education agencies}** shall adopt oral health standards as part of the **{insert state}** physical education and health curriculum framework.

Section 3. Establishment of Oral Health Educational Program.

The **{insert applicable state education agencies}** shall work with public schools to establish an educational program to inform, train, and educate students concerning the importance of achieving and maintaining good oral health.

Section 4. Curricula.

Curricula shall be designed according to objectives established by the **{insert applicable state education agencies}**.

Section 5. Grade Specific Objectives, Incorporation into Existing Curricula.

The objectives shall be grade specific and shall be incorporated into the appropriate existing health and science curricula.

Section 6. Implementation.

It is the intent of this section that the curricula shall be implemented gradually, on a basis to be determined by the department, beginning no later than **{insert date}**, with early elementary curricula and reaching full implementation at the high school level no later than **{insert date}**.

Section 7. Voluntary Assistance to Achieve Purposes of Section.

The **{insert applicable state education agencies}** shall enlist the voluntary assistance of appropriate dental health professionals, organizations, and departments as necessary to achieve the purposes of this section.

Section 8. {Severability clause.}
Section 9. {Repealer clause.}
Section 10. {Effective date.}

Patient Access Expansion Act
(DRAFT, December 5, 2013)

Summary

This Act prohibits maintenance of licensure, maintenance of certification, and specialty certification as state requirements to practice medicine. It also prohibits the state medical board from funding the Federation of State Medical Boards.

Model Legislation

Section 1. Short Title. This Act shall be known as the "Patient Access Expansion Act."

Section 2. Prohibition of Maintenance of Licensure, Maintenance of Certification, Specialty Certification to Practice Medicine.
This state of {**insert state**} is prohibited from requiring any form of maintenance of licensure, maintenance of certification, or original certification by a specialty medical board, in order to practice medicine within the state.

Section 3. Prohibition of State Funding of Federation of State Medical Boards.
The {**insert state medical board**} is prohibited from funding the Federation of State Medical Boards (FSMB). Funds from physician licensures shall not be sent to FSMB and the state of {**insert state**} shall not permit any money to be awarded to FSMB from this state.

Section 4. {**Severability Clause**}
Section 5. {**Repealer Clause**}
Section 6. {**Effective Date**}

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Sunset Review

Health & Human Services Task Force

Affordable Health Insurance Act

Cancer Drug Donation Program Act

Freedom of Choice in Health Care Act

Health Care Sharing Ministries Tax Parity Act

Rescission External Review Act

Resolution in Support of the PhRMA Code and Corporate Self-Regulation

Resolution on Ensuring Access to Convenient Care Clinics

Resolution on Medicaid Funding Through a Federal Block Grant

SCHIP Anti-Crowd-Out Act

Taking the Best – ALEC's Comprehensive Medical Liability Reform Proposal

Affordable Health Insurance Act

Model Legislation

Section 1. Short Title. This Act may be cited as the "Affordable Health Insurance Act."

Section 2. Insurers that include and operate wellness and health promotion programs, disease and condition management programs, health risk appraisal programs, and similar provisions in their high deductible health policies in keeping with federal requirements shall not be considered to be engaging in unfair trade practices under **{insert appropriate provision of state law}** with respect to references to the practices of illegal inducements, unfair discrimination, and rebating.

Section 3.
A. There shall be no required relationship between preferred provider and nonpreferred provider plan reimbursements for Health Savings Account eligible high deductible plans using nonpreferred provider reimbursements. Such plans, however, shall not:

1. Unfairly deny health benefits for medically necessary covered services;

2. Have differences in benefit levels payable to preferred providers compared to other providers that unfairly deny benefits for covered services;

3. Have a plan coinsurance percentage applicable to benefit levels for services provided by nonpreferred providers that is less than 60 percent of the benefit levels under the policy for such services; or

4. Have an adverse effect on the availability or the quality of services.

Section 4.
A. The Commissioner of Insurance shall be authorized to allow Health Reimbursement Arrangement only plans that encourage employer financial support of health insurance or health related expenses recognized under the rules of the federal Internal Revenue Service.

B. Health Reimbursement Arrangement only plans that are not sold in connection with or packaged with health insurance coverage shall not be considered insurance under the laws of this state.

C. Individual health insurance policies funded through Health Reimbursement Arrangement only plans shall not be considered employer sponsored or group coverage under the laws of this state, and nothing in this Section shall be interpreted to require an

insurer to offer an individual health insurance policy for sale in connection with or packaged with a Health Reimbursement Arrangement only plan or to accept premiums from Health Reimbursement Arrangement only plans for individual health insurance policies.

Section 5. In addition to other deductions allowed by law, a taxpayer in this state may deduct from his or her taxable income for state income tax purposes an amount equal to 100 percent of the premium paid by the taxpayer during the taxable year for high deductible health plans which are eligible to be used with a Health Savings Account under the applicable provisions of Section 223 of the Internal Revenue Code to the extent the deduction has not been included in federal adjusted gross income, as defined under the Internal Revenue Code of 1986, and the expenses have not been provided from a Health Reimbursement Arrangement and have not been included in itemized nonbusiness deductions that shall be excluded from such taxpayer's taxable income.

Section 6.

A. As used in this Section, the following definitions apply:

1. "Qualified health insurance" means a high deductible health plan that includes, at a minimum, catastrophic health care coverage which is eligible to be used with a Health Savings Account under the applicable provisions of Section 223 of the Internal Revenue Code.

2. "Qualified health insurance expense" means the expenditure of funds of at least $250.00 annually for health insurance premiums for qualified health insurance.

3. "Taxpayer" means an employer who employs directly, or who pays compensation to individuals whose compensation is reported on Form 1099, 50 or fewer persons and for whom the taxpayer provides high deductible health plans that include, at a minimum, catastrophic health care coverage which are established and used with a Health Savings Account under the applicable provisions of Section 223 of the Internal Revenue Code and in which such employees are enrolled.

B. A taxpayer shall be allowed a credit against the income tax imposed by **{insert applicable tax provisions for income tax of employers}**, as applicable, for qualified health insurance expenses in an amount of $250.00 for each employee enrolled for twelve consecutive months in a qualified health insurance plan if such qualified health insurance is made available to all of the employees and compensated individuals of the employer pursuant to the applicable provisions of Section 125 of the Internal Revenue Code.

C. In no event shall the total amount of the tax credit under this section for a taxable year exceed the taxpayer's income tax liability. Any unused tax credit shall be allowed the taxpayer against succeeding years' tax liability. No such credit shall be allowed the taxpayer against prior years' tax liability.

D. The **{insert title of appropriate taxing authority}** shall be authorized to promulgate any rules and regulations necessary to implement and administer the provisions of this Section.

E. The credit allowed by this Section shall apply only with regard to qualified health insurance expenses.

Section 7.
[Drafting Note: This Section should be used as language for exemption from the insurance premium tax, if state or local governments have such a tax.)

A. Insurers in this state shall be exempt from otherwise applicable state taxes on insurance premiums paid by residents of this state for high deductible health plans eligible to be used with a Health Savings Account under the applicable provisions of Section 223 of the Internal Revenue Code.

Section 8. It is the intent of the legislature:

A. To authorize the Commissioner of Insurance to establish flexible guidelines for Health Savings Account eligible high deductible plan designs which will be affordable to citizens of this state and to increase the availability of these types of plans by accident and sickness insurers licensed to transact such insurance in this state;

B. To encourage the offering of affordable Health Savings Account eligible high deductible plans, as required under the rules of the federal Internal Revenue Service related to the establishment of Health Savings Accounts, with the specific intent of reaching many otherwise uninsured citizens of this state and the general intent of creating affordable comprehensive health insurance for all citizens of this state; and

C. To enhance the affordability of insurance with the flexible Health Savings Account eligible high deductible plans allowed under **{insert appropriate chapter}** by allowing rewards and incentives for participation in and adherence to health behaviors that recognize the value of the personal responsibility of each citizen to maintain good health, seek preventive care services, and comply with approved treatments.

Section 9.
A. The Commissioner of Insurance shall develop flexible guidelines for coverage and approval of Health Savings Account eligible high deductible plans which are designed to qualify under federal and state requirements as high deductible health plans for use with Health Savings Accounts which comply with federal requirements under the applicable provisions of the federal Internal Revenue Code for high deductible health plans sold in connection with Health Savings Accounts.

B. The Commissioner of Insurance shall be authorized to encourage and promote the marketing of Health Savings Account eligible high deductible plans by accident and sickness insurers in this state; provided, however, that nothing in this section shall be construed to authorize the sale of insurance in violation of the requirements of law relating to the transaction of insurance in this state or prohibiting the interstate sale of insurance.

C. The Commissioner of Insurance shall be authorized to conduct a national study of Health Savings Account eligible high deductible plans available in other states and to determine if and how these products serve the uninsured and if they should be made available to the citizens of this state.

D. The Commissioner of Insurance shall be authorized to develop an automatic or fast track approval process for Health Savings Account eligible high deductible plans already approved under the laws and regulations of this state or other states.

E. The Commissioner of Insurance shall be authorized to promulgate such rules and regulations as he or she deems necessary and appropriate for the design, promotion, and regulation of Health Savings Account eligible high deductible plans, including rules and regulations for the expedited review of standardized policies, advertisements and solicitations, and other matters deemed relevant by the Commissioner.

Section 10. Effective Date. Sections 8, 9, and 10 of this Act shall become effective on **{insert date}** and shall be applicable to all taxable years beginning on and after that date. The remaining Sections of this Act shall become effective on **{insert date}**.

Approved by the Board of Directors on January 14, 2009.

Cancer Drug Donation Program Act

Model Legislation

Section 1. Title. This Act shall be known as the "Cancer Drug Donation Program Act."

Section 2. Definitions. For purposes of the Cancer Drug Donation Program Act, the following definitions apply:

(1) "Cancer drug" means a prescription drug used to treat cancer or its side effects or used to treat the side effects of a prescription drug used to treat cancer or its side effects. "Cancer drug" does not include drugs for the treatment of cancer that can only be dispensed to a patient registered with the drug manufacturer in accordance with federal Food and Drug Administration requirements;

(2) "Department" means the **{insert state agency}**;

(3) "Donor" means a person, health care facility, hospital, pharmacy, drug manufacturer, medical device manufacturer or supplier, wholesaler of drugs or supplies or any other entity that donates cancer drugs, or supplies needed to administer such drugs, in accordance with this Act;

(4) "Health care facility" means a health care facility licensed in accordance with Section **{insert section}**;

(5) "Health clinic" means a health care clinic licensed in accordance with Section **{insert section}**;

(6) "Hospital" means a facility licensed in accordance with Section **{insert section}**;

(7) "Participant" means a physician's office, pharmacy, hospital, hospice, or health clinic that has elected to participate in the program and that accepts donated cancer drugs and supplies under the rules and regulations adopted and promulgated by the Department for the Program;

(8) "Pharmacy" means an entity licensed under Section **{insert section}**;

(9) "Physician's office" means the office of a person licensed to practice medicine and surgery or osteopathic medicine;

(10) "Prescribing practitioner" means a health care practitioner licensed under Sections **{insert sections}** who is authorized to prescribe cancer drugs;

(11) "Prescription drug" means a drug as defined in Section **{insert section}**;

(12) "Program" means the Cancer Drug Donation Program created by this Act;

(13) "Supplies" means any supplies used in the administration of a cancer drug.

Section 3.
Any person or entity may donate cancer drugs to the Program. Cancer drugs may be donated at a physician's office, pharmacy, hospital, hospice, or health clinic that elects to participate in the program and meets criteria established by the department for such participation. Cancer drugs will not be donated to a specific cancer patient. No such donated drugs or supplies may be resold by the Program.

Section 4.
The cancer drug or supplies donated to the Program must be prescribed by a practitioner for use by an eligible individual and dispensed by a pharmacist.

Section 5.
(1) A cancer drug or supplies shall only be accepted or dispensed under this Program if such drug is in its original, unopened, sealed, and tamper-evident unit dose packaging, except that a cancer drug packaged in single unit doses may be accepted and dispensed if the outside packaging is opened but the single-unit-dose packaging is unopened.

(2) A cancer drug shall not be accepted or dispensed under this Program if such drug bears an expiration date that is no later than **{insert length of time}** after the date the drug was donated, or if such drug is adulterated or misbranded as determined in paragraph 3 below.

(3) Prior to dispensing to a patient, the cancer drug or supplies donated under this Program must be inspected by a pharmacist to determine that the drug and supplies are not adulterated or misbranded.

(4) Any dispenser of donated products shall not submit a claim or otherwise seek reimbursement from any public and/or private third party payer for donated drugs dispensed to any patient in accordance with this program, and no public or private third party payers shall be required to provide reimbursement for donated drugs dispensed to any patient through this program.

Section 6.
(1) A physician's office, pharmacy, hospital, hospice, or health clinic that accepts donated cancer drugs under the Program shall comply with all applicable provisions of state and federal law relating to the storage, distribution, and dispensing of such donated cancer drugs.

(2) A physician's office, pharmacy, hospital, hospice, or health clinic who participates in the Program may charge a nominal handling fee for distributing or dispensing cancer

drugs under the Program. Such fee shall be established in rules and regulations adopted and promulgated by the department.

Section 7.
Individuals who meet the eligibility standards for this Cancer Drug Donation Program shall not include patients who are eligible to receive drugs under the state Medicaid Program or under any other prescription drug program funded in whole or in part by the state.

Section 8.
The department, upon the recommendation of the Board of Pharmacy, shall adopt and promulgate rules and regulations to carry out the provisions of this Act. Initial rules and regulations under the Act shall be adopted and promulgated no later than ninety days after the effective date of this Act. Such rules and regulations shall include, but not be limited to:

(1) Eligibility criteria, including a method to determine priority of recipients under this Program.

(2) Standards and procedures for participants that accept, store, distribute or dispense donated cancer drugs or supplies;

(3) Necessary forms for administration of the Program, including, but not limited to, forms for use by persons or entities that donate, accept, distribute, or dispense cancer drugs or supplies under the Program;

(4) The maximum handling fee that may be charged by a participant that accepts and distributes or dispenses donated cancer drugs or supplies;

(5) Categories of cancer drugs and supplies that the Program will accept for dispensing;

(6) Categories of cancer drugs and supplies that the Program will not accept for dispensing and the reason that such drugs and supplies will not be accepted; and

(7) Maintenance and distribution of the participant registry established in Section 8 of this Act.

Section 9.
The department shall establish and maintain a participant registry for the program. The participant registry shall include the participant's name, address, and telephone number and shall identify whether the participant is a physician's office, a pharmacy, a hospital, a hospice, or a health clinic. The department shall make the participant registry available to any person or entity wishing to donate cancer drugs to the Program.

Section 10.

Any donor of a cancer drug or supplies, or a participant in the Program who exercises reasonable care in donating, accepting, distributing or dispensing cancer drugs or supplies under the **{insert "Cancer Drug Donation Program Act" or name of a similar state program, a Patient Assistance Program, or a Compassionate Use Program}** and the rules and regulations adopted and promulgated under the Act, shall be immune from civil or criminal liability and from professional disciplinary action of any kind for any injury, death, or loss to person or property relating to such activities.

Section 11.

No pharmaceutical manufacturer shall be liable for any claim or injury arising from the transfer of any prescription drug pursuant to the provisions of this Act, including but not limited to liability for failure to transfer or communicate product or consumer information regarding the transferred drug, as well as the expiration date of the transferred drug.

Section 12. {Severability Clause}

Section 13. {Repealer Clause}

Section 14. {Effective Date}

Approved by the Health and Human Services Task Force on August 5, 2005.
Amended by the Health and Human Services Task Force on May 18, 2008.

Freedom of Choice in Health Care Act

Model Legislation

Section 1. Short Title. This Act may be cited as the "Freedom of Choice in Health Care Act."

Section 2. The people have the right to enter into private contracts with health care providers for health care services and to purchase private health care coverage. The legislature may not require any person to participate in any health care system or plan, nor may it impose a penalty or fine, of any type, for choosing to obtain or decline health care coverage or for participation in any particular health care system or plan.

Section 3. {Severability Clause.}

Section 4. {Repealer Clause.}

Section 5. {Effective Date.}

Passed by the Health and Human Services Task Force on December 6, 2008.
Approved by the Board of Directors on January 14, 2009.

Health Care Sharing Ministries Tax Parity Act

FINDINGS AND PURPOSE

Members of health care sharing ministries financially assist fellow members with large medical expenses with a result usually provided by health insurance. Due to their positive contribution to our health care system, moneys spent and received for assistance by members of health care sharing ministries should have at least the same advantages under the income tax code as do health insurance premiums and reimbursements.

A health care sharing ministry (HCSM) is a health care cost sharing arrangement among persons of similar and sincerely held beliefs, administered by a not-for-profit religious organization. Those sharing through HCSMs are called members, and the money sent by members to other members to help pay for their medical expenses is called a share. The sharing is accomplished through members' monthly gifts directed to families in financial distress and not to an insurance reserve fund. In addition to addressing the financial needs of those facing health challenges, HCSMs also seek to help meet spiritual and emotional needs as of part the sense of community which exists among members.

HCSMs represent over 100,000 members in all fifty states. HCSMs share over 60 million dollars per year for health care costs.

Since 1981, formalized HCSMs have played a vital role in assisting tens of thousands of individuals emotionally, spiritually, and financially through medical crises and the accompanying expenses.

Under the federal Internal Revenue Code, employers who purchase health insurance for their employees may deduct the cost as a business expense, while at the same time it is a nontaxable fringe benefit to the employee. The self-employed and employees who purchase their own health insurance may, in most circumstances, also deduct that cost on their income tax returns. Also, health insurance reimbursements for medical expenses are not considered taxable income.

Like health insurance policy holders, members of HCSMs make payments that go toward assisting fellow members with medical expenses. However, due to the fact that HCSMs are not insurance companies and are not well known, the federal and state tax codes do not explicitly address their status. The deductibility of HCSM payments is unclear, and the non-taxability of the gifts received from HCSM members to help those with large expenses is not as clear as it should be.

In 2007, Missouri became the first state to amend its income tax code to allow a full personal deduction of HCSM expenses. (See Section 143.11&1 RSM.) This legislation is designed so that HCSMs are given at least equal treatment with health insurance. This includes personal and business deductibility for HCSM payments; tax-free fringe benefit for employer provided HCSM memberships; and non-taxability of gifts received from HCSM members to assist with medical expenses.

MODEL LEGISLATION

Section 1. Short Title. This Act shall be known as the "Health Care Sharing Ministries Tax Parity Act."

Section 2. Definitions. As used in this Act, the following definition applies:

A. "Health care sharing ministry" means a health care cost sharing arrangement among persons of the same religion based on their sincerely held religious beliefs, administered by a not-for-profit religious organization.

(Drafting Note: The following language may be used as an alternate Paragraph A.)

A. "Health care sharing ministry" means a faith-based, non-profit organization that is tax-exempt under the Internal Revenue Code which:

1. Limits its membership to those who are of a similar faith;

2. Acts as an organizational clearinghouse for information about members/subscribers who have financial, physical or medical needs, matching them with members/subscribers with the present ability to assist those with financial or medical needs, all in accordance with the organization's criteria;

3. Provides for the financial or medical needs of a member/subscriber through payments directly from one member/subscriber to another. The requirements of this Subsection can be satisfied by a trust established solely for the benefit of members/subscribers, which is audited annually by an independent auditing firm;

4. Provides amounts that members/subscribers may contribute with no assumption of risk or promise to pay among the members/subscribers and no assumption of the risk or promise to pay by such organization to the members/subscribers;

5. Provides a written monthly statement to all members/subscribers, listing the total dollar amount of qualified needs submitted to such organization, members/subscribers for their contribution; and

6. Provides in substance the following written disclaimer on or accompanying all promotional documents distributed by or on behalf of the organization, including applications, and guideline materials:

"Notice: This publication is not an insurance company nor is it offered through an insurance company. Whether anyone chooses to assist you with your medical bills will be totally voluntary, as no other subscriber or member will be compelled by law to contribute toward your medical bills. As such, this publication should never be considered to be insurance. Whether you receive any payments for medical expenses and whether or not this publication continues to operate, you are always personally responsible for the payment of your own medical bills."

Section 3. Income Tax Deductions and Credits.

A. Whenever in this **{insert code, title, chapter, or appropriate description that describes the state's regulation of health insurance statutes}** a deduction or credit is allowed for expenditures for "medical care" or health insurance premiums, expenditures by a taxpayer as a member, or the employer of a member, of a health care sharing ministry (and such expenditures by a member of a health care sharing ministry's employer with respect to deductions or credits allowed employers) shall qualify for said deduction or credit.

Section 4. **Determining Adjusted Gross Income**.

A. For purposes of determining an individual's state adjusted gross income for a taxable year, the individual's federal adjusted gross income for that taxable year shall have subtracted from it any amounts included therein due to:

1. Amounts the individual received as a member of a health care sharing ministry; and

2. Amounts the individual's employer paid on behalf of the individual as part of the individual's membership in a health care sharing ministry.

(Drafting Note: The above language is drafted for those states whose state income tax derives a person's state taxable income from the person's federal adjusted gross income. The following language may be used as an alternate Paragraph A for those states whose income tax is calculated independent from the federal income tax.)

A. The following shall be excluded from income for purposes of determining an individual's adjusted gross income for a taxable year:

1. Amounts the individual received as a member of health care sharing ministry; and

2. Amounts the individual's employer paid on behalf of the individual as part of the individual's membership in a health care sharing ministry.

Section 5. {Severability Clause.}

Section 6. {Repealer Clause.}

Section 7. {Effective Date.}

Passed by the Health and Human Services Task Force on May 17, 2008.

Rescission External Review Act

Model Legislation

Section 1. Short Title. This Act may be cited as the "Rescission External Review Act."

Section 2. Purpose. The purpose of this Act is to assure that covered persons have an opportunity for an independent external review when coverage is rescinded.

Section 3. Definitions. When used in this Act, the following definitions apply:

A. "Authorized representative" means a person to whom a covered person has given express written consent to represent the covered person in an external review.

B. "Independent review organization" means an entity that conducts independent external reviews of rescission determinations.

C. "Rescission determination" means an initial determination involving a rescission or modification of coverage as a result of a material misstatement or fraud, including a determination that has been upheld by a health insurer at the completion of the health insurer's internal grievance procedures.

Section 4. Applicability and Scope.

A. Except as provided in Paragraph B, this Act shall apply to all health insurers offering health insurance coverage to residents of this state.

B. The provisions of this Act shall not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance, vision care, or any other limited supplemental benefit or to a Medicare supplement policy of insurance, as defined by the **{insert state insurance commissioner}** by regulation, coverage under a plan through Medicare, Medicaid, or the federal employees health benefits program, any coverage issued under Chapter 55 of Title 10, U.S. Code and any coverage issued as supplement to that coverage, any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis.

Section 5. Required Disclosures.

A. Within **{insert time frame otherwise required by state law}** of issuing a health insurance contract, the health insurer shall send a copy of the completed written application to the applicant with a copy of the health insurance contract issued by the health insurer, along with a notice that states all of the following:

1. The applicant should review the completed application carefully and notify the health insurer within **{insert time frame otherwise required by state law}** of any inaccuracy in the application.

2. Any material misrepresentation or material omission in the information submitted in the application may result in the cancellation or rescission of the plan contract.

3. The applicant should retain a copy of the completed written application for the applicant's records.

B. If new information is provided by the applicant within the time frame permitted by Paragraph A, the health insurer shall review that information and make the appropriate change to its underwriting determination.

Section 6. Medical History Review.

A. Once a health insurer has issued an individual health insurance contract, the health insurer shall not rescind or cancel the health insurance contract unless all of the following apply:

1. There was a material misrepresentation or material omission in the information submitted by the applicant in the written application to the health insurer prior to the issuance of the health insurance contract that would have materially affected the underwriting classification or eligibility decision.

2. The health insurer maintains and has relied upon written medical underwriting policies and procedures in making the determination to issue an individual health insurance contract.

3. The applicant misrepresented or omitted material information on the application prior to the issuance of the health insurance contract.

4. The health insurer sent a copy of the completed written application to the applicant with a copy of the health insurance contract issued by the health insurer, along with the written notice required by Section 5.

B. If a health insurer obtains information after issuing an individual health insurance contract that the covered individual may have omitted or misrepresented material information during the application for coverage process, the health insurer may investigate the potential omissions or misrepresentations in order to determine whether the health insurance contract should be amended, rescinded or canceled.

C.

1. Upon initiating an investigation for potential rescission or cancellation of a health insurance contract, the health insurer shall provide a written notice to the covered individual that it has initiated a claims investigation. The notice shall be provided by the health insurer within 10 days of the initiation **{or insert other time frame identified in a state's prompt pay or clean claims law}** of the investigation.

2. The health insurer shall complete its investigation, and provide written notice of its decision no later than 30 days from the date of the notice sent to the covered individual. The health insurer may stop the 30 days from running if it needs to obtain additional information to complete the investigation. *(Drafting note: This time frame should be adjusted to be consistent with a state's clean claims or prompt pay law.)*

D. Upon completion of its post-issuance investigation, the health insurer shall provide written notice to the covered individual that it has concluded its investigation and has made one of the following determinations:

1. The health insurer determined that the covered individual did not misrepresent or omit material information during the application process and that the subscriber's or enrollee's health insurance contract will not be canceled or rescinded.

2. The health insurer intends to amend, cancel, or rescind the health insurance contract for misrepresentation or omission of material information during the application for coverage process. The notice must also include all procedures required to request a review under the health insurer's appeal or complaint process.

3. The health insurer shall provide the covered individual with the opportunity to provide any evidence or information within 30 days of the final determination that would affect the decision to rescind, cancel, or modify coverage.

Section 7. Notice of Right to External Review.

A.

1. A health insurer shall notify the covered person in writing of the covered individual's right to request an external review at the same time the health insurer sends written notice of a rescission determination upon completion of the health carrier's grievance process, if required; and

2. As part of the written notice required under Paragraph A, Subparagraph 1, a health insurer shall include the following, or substantially equivalent, language: "We have rescinded your health insurance coverage. You have the right to have our decision reviewed by an independent external review entity by submitting a request for external review to the **{insert state insurance commissioner; insert address and telephone number of the state insurance commissioner's office or other unit in the office that administers the external review program}**."

Section 8. Request for External Review.

A.

1. All requests for external review shall be made in writing to the **{insert state insurance commissioner}**.

2. The **{insert state insurance commissioner}** may prescribe by regulation the form and content of external review requests required to be submitted under this section *(Drafting note: These forms should be consistent with appeals forms or procedures already in place.)*

B. A covered individual or the covered individual's authorized representative may make a request for an external review. *(Drafting note: This Section should be consistent with a state's external review process.)*

Section 9. Process for Requesting External Review.

A. A request for an external review shall not be made until the covered individual has exhausted the health insurer's internal appeal process. A health insurer may waive the requirement that an individual exhaust the insurer's internal grievance process.

B.

1. Within 30 days after the date of receipt of a notice of a rescission determination pursuant to this Act, a covered individual or the covered individual's authorized representative may file a request for an external review with the **{insert state insurance commissioner}**.

2. Within 10 business days after the date of receipt of a request for external review pursuant to Paragraph B, Subparagraph 1, the **{insert state insurance commissioner}** shall send a copy of the request to the health carrier.

C. Within 10 business days following the date of receipt of the copy of the external review request from the **{insert state insurance commissioner}** under Paragraph B, Subparagraph 1, the health insurer shall complete a preliminary review of the request to determine whether:

1. The covered individual has exhausted the health insurer's internal appeal unless the covered person is not required to exhaust the health insurer's internal appeal process pursuant to Section 7 of this Act; and

2. The covered person has provided all the information and forms required to process an external review.

D.

1. Whenever the **{insert state insurance commissioner}** receives a notice that a request is eligible for external review following the preliminary review conducted pursuant to Paragraph B, within 10 business days after the date of receipt of the notice, the {insert state insurance commissioner} shall:

a. Randomly assign an independent review organization from the list of approved independent review organizations compiled and maintained by the **{insert state insurance commissioner}** pursuant this Act to conduct the external review and notify the health insurer of the name of the assigned independent review organization, and

b. Notify in writing the covered person and, if applicable, the covered individual's authorized representative of the request's eligibility and acceptance for external review.

E. Within 10 business days after the date of receipt of the notice provided, the health insurer shall provide to the assigned independent review organization the documents and any information considered in making the rescission determination.

F.

1. Upon receipt of the information, if any, required to be forwarded pursuant to Paragraph D, the health insurer may reconsider its rescission determination that is the subject of the external review.

2. Reconsideration by the health insurer of its rescission determination pursuant to Paragraph F, Subparagraph 1 shall not delay or terminate the external review.

3. The external review may only be terminated if the health insurer decides, upon completion of its reconsideration, to reverse its rescission determination and provide coverage or payment for the health care service that is the subject of the rescission determination.

4.

a. Within three business days after making the decision to reverse its rescission determination, as provided in Paragraph F, Subparagraph 3, the health insurer shall notify the covered person, if applicable, the covered individual's authorized representative, the assigned independent review organization, and the **{insert state insurance commissioner}** in writing of its decision.

b. The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to Subparagraph 4(a) of this Paragraph.

G.

1. The independent review organization shall select a panel of health care professional reviewers and legal reviewers to conduct the independent review within 10 business days after being assigned by the {insert state insurance commissioner} to conduct an external review.

2. The panel shall consist of three legal reviewers and must include individuals with expertise and knowledge of the individual health insurance market, including the underwriting process. In the event that the external review requires medical expertise, the legal reviewers shall consult with a health care professional.

3. In selecting the third party review panel, the assigned third party review organization shall select physicians, health care professionals, and attorneys who meet the following qualifications:

a. All legal reviewers assigned by a third party review organization to conduct third party reviews shall be licensed attorneys who:

(1) Have demonstrated expertise in contract and insurance law with knowledge of the individual health insurance market, including the underwriting process,

(2) Holds a non-restricted license to practice law in any state or the District of Columbia,

(3) Has no history of disciplinary actions or sanctions that have been taken or are pending by any state bar association, regulatory body or court of law that raise a substantial question as to the legal reviewer's physical, mental, or professional competence or moral character, and

(4) Have no fiduciary interest in legal action against or in defense of a health insurance carrier, nor may they use information obtained during an external review in any subsequent legal action against or in defense of a health insurance carrier.

b. All health care professional consultants shall be physicians or other appropriate health care providers who:

(1) Are knowledgeable about the relevant health care service or treatment that was misrepresented or omitted through recent or current actual clinical experience treating patients with the same or similar medical condition of the covered person,

(2) Hold a non-restricted license in any state or the District of Columbia and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the third party review, and

(3) Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency, or unit, or regulatory body that raise a substantial question as to the health care professional reviewer's physical, mental, or professional competence or moral character.

H.

1. Within 15 days after the date of receipt of the request for an external review—or within 30 days if the assigned independent review organization sends written notice to all parties after 15 days—the assigned independent review organization shall provide written notice of its decision to uphold or reverse the rescission determination to:

a. The covered individual,

b. If applicable, the covered individual's authorized representative,

c. The health insurer, and

d. The **{insert state insurance commissioner}**.

2. The independent review organization shall include in the notice sent pursuant to Paragraph H, Subparagraph 1:

a. A general description of the reason for the request for external review,

b. The date the independent review organization received the assignment from the **{insert state insurance commissioner}** to conduct the external review,

c. The date the external review was conducted,

d. The date of its decision,

e. The principal reason or reasons for its decision, and

f. The rationale for its decision.

(Drafting note: All timeframes in this Section should be consistent with a state's existing external review law in order to ensure consistency and ease of compliance.)

Section 10. Approval of Independent Review Organizations.

A. The **{insert state insurance commissioner}** shall approve independent review organizations eligible to be assigned to conduct external reviews under this Act.

B. The **{insert state insurance commissioner}** shall develop rules including an application form for initially approving and for reapproving independent review organizations to conduct external reviews.

1. Any independent review organization wishing to be approved to conduct external reviews under this Act shall submit the application form and include with the form all documentation and information necessary for the **{insert state insurance commissioner}** to determine if the independent review organization satisfies the minimum qualifications established under this Act and rules developed by the **{insert state insurance commissioner}**.

2.

a. Subject to Subparagraph 2(b) of this Paragraph, an independent review organization is eligible for approval under this Section only if it is accredited by a nationally recognized private accrediting entity that the **{insert state insurance commissioner}** has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications for independent review organizations under this Act.

b. The **{insert state insurance commissioner}** may approve independent review organizations that are not accredited by a nationally recognized private accrediting entity if there are no acceptable nationally recognized private accrediting entities providing independent review organization accreditation.

C.

1. In addition to the requirements set forth in this Act to be approved pursuant this Act to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor any reviewer assigned by the independent organization to conduct the external review may have a material professional, familial or financial conflict of interest with any of the following:

a. The health insurer that is the subject of the external review,

b. The covered individual whose treatment is the subject of the external review or the covered person's authorized representative,

c. Any officer, director, or management employee of the health carrier that is the subject of the external review,

d. The health care provider, the health care provider's medical group, or independent practice association recommending the health care service or treatment that is the subject of the external review, or

e. The facility at which the recommended health care service or treatment would be provided.

2. In determining whether an independent review organization or a clinical reviewer of the independent review organization has a material professional, familial or financial conflict of interest for purposes of Paragraph C, Subparagraph 1, the **{insert state insurance commissioner}** shall take into consideration situations where the independent review organization to be assigned to conduct an external review of a specified case or a clinical reviewer to be assigned by the independent review organization to conduct an external review of a specified case may have an apparent material professional, familial, or financial relationship or connection with a person described in Paragraph C, Subparagraph 1, but that the characteristics of that relationship or connection are such that they are not a material professional, familial,

or financial conflict of interest that results in the disapproval of the independent review organization or the clinical reviewer from conducting the external review.

(Drafting note: This Section should be consistent with any existing state requirements in order to ensure ease of administration by the regulating entity.)

Section 11. Binding Nature of External Review Decision.

A. A third party review decision is binding on the health carrier to the extent that the health carrier has other remedies available under applicable federal or state law. The results of the external review process shall be admissible in any subsequent legal proceeding associated with a rescissions action as allowed by state or federal law.

B. A covered individual or that covered individual's authorized representative may not file a subsequent request for third party review involving the same rescission decision for which the covered individual has already received a third party review decision pursuant to this Act.

Section 12. Exhaustion of Third Party Review Process. A covered person or the covered person's authorized representative may not pursue litigation of a health carrier's decision to rescind a policy until the covered person has exhausted the third party review process set forth in this Act.

Section 13. Funding of External Review. The health insurer against which a request for a standard external review or an expedited external review is filed shall pay the cost of the independent review organization for conducting the external review.

(Drafting note: This should be consistent with a state's existing requirements.)

Section 14. Severability. If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 15. {Repealer Clause.}

Section 16. {Effective Date.}

Passed by the Health and Human Services Task Force on December 6, 2008.
Approved by the Board of Directors on January 14, 2009.

Resolution In Support of the PhRMA Code and Corporate Self-Regulation

WHEREAS, Health care is an expanding portion of state budgets; and

WHEREAS, Prescription medicines, which comprise only 10 cents per health care dollar spent, are being used more frequently to treat diseases, including chronic diseases, and

WHEREAS, Prescription medicines have an essential role in treating chronic diseases, as do changes in personal behavior, such as diet and exercise; and

WHEREAS, America's pharmaceutical companies are responsible for the discovery and development of the majority of new medicines available to patients in the United States and worldwide each year; and

WHEREAS, New medicines save lives, improve health, and reduce many health care costs, and

WHEREAS, Pharmaceutical companies have the most current information about all aspects of their medicines, and

WHEREAS, Providers need to make decisions based on their knowledge of both medicines and individual patients, and

WHEREAS, Patients and providers need the assurance that providers have the most current information about treatment options to make the best decisions about what specific medicine to prescribe for which patient; and

WHEREAS, ALEC believes that the private sector will provide the most patient-centered, efficient, innovative health care for Americans, and

WHEREAS, PhRMA has adopted a revised *Code on Interactions with Healthcare Professionals* that explicitly affirms that pharmaceutical company "interactions with healthcare professionals are professional exchanges designed to benefit patients and to enhance the practice of medicine"; and

WHEREAS, PhRMA has provided a mechanism by which physicians, patients, and the general public can confirm whether an individual pharmaceutical company has agreed to abide by the *PhRMA Code on Interactions with Healthcare Professionals*; and

WHEREAS, *PhRMA Code on Interactions with Healthcare Professionals* encourages companies to seek external verification that the company has policies and procedures in place to foster compliance with the Code.

NOW THEREFORE BE IT RESOLVED THAT ALEC endorses the new PhRMA Code and commends PhRMA for its adoption of both the Code and the public system for identifying companies that have agreed to abide by the Code.

Passed by the Health and Human Services Task Force on December 6, 2008.
Approved by the Board of Directors on January 14, 2009.

ALEC American Legislative Exchange Council

LIMITED GOVERNMENT • FREE MARKETS • FEDERALISM

RESOLUTION ON ENSURING ACCESS TO CONVENIENT CARE CLINICS

WHEREAS, **{Insert state legislative body}** finds that access to health care is important to its citizens; and

WHEREAS, {Insert state legislative body} finds that state legislators can have a profound impact on the affordability, accessibility, and availability of basic health care services; and

WHEREAS, {Insert state legislative body} finds that the citizens of **{insert state}** should have affordable and accessible options with regard to where they receive their medical treatment; and

WHEREAS, {Insert state legislative body} finds that convenient care clinics (CCCs):

- Provide consumers convenient access to non-emergency health care services,
- Provide consumers earlier access to health care by encouraging preventive care,
- Alleviate stress on overburdened emergency rooms, and
- Help the uninsured get affordable services; and

WHEREAS, {Insert state legislative body} finds that legislators can help consumers by supporting the convenient care clinic model in which health care professionals bring benefits to the community, including:

- Flexible hours with clinics open seven days a week, including evening hours,
- Expedient access to care with no appointments necessary,
- Convenient locations in settings accessible to the public,
- Affordable services to all patients with many insurance plans commonly accepted,
- Transparent prices for services that are readily available in a visible place outside of the examination room,
- Portable Electronic Health Records that coordinate care and ensure safety, and

- Easy referral to the medical home model by connecting patients with primary care providers and other providers, as needed, including specialists and emergency services providers; and

WHEREAS, {Insert state legislative body} finds that convenient care clinics have taken appropriate steps to provide consistent and high-quality care including:

- Adherence to industry-wide mandatory quality and safety standards and commitment to provide patients with timely and accurate treatment from qualified health care professionals,

- Compliance with all governing laws and regulations regarding provider certification, clinical facilities, and infection control (including CLIA, OSHA and ADA standards and HIPAA and CDC guidelines),

- Quality assurance on an ongoing basis though peer review, collaborating physician review (collaborating physician review only where and to what extent mandated by local rule/law), use of evidence-based guidelines, collection of aggregate data on selected quality and safety outcomes, and collection of patient satisfaction data,

- Utilization of Electronic Medical Records to ensure high-quality, efficient care, and

- Opportunity for all patients to share health information with their other providers electronically or in paper format; and

WHEREAS, {Insert state legislative body} finds that some states have considered policy that could slow the growth of convenient care clinics including:

- Mandates whereby advanced practice nurses must enter into restrictive collaborative agreements with physicians, and

- Regulatory mandates for retail health clinics that are not required by physician or other health clinics.

THEREFORE BE IT RESOLVED THAT {Insert state legislative body} finds convenient care clinics provide accessible, cost-effective, high-quality care that allows patients to receive the care they need with minimal disruption to their lives and alleviates some of the burden on the existing, traditional health care infrastructure.

Approved by the Health and Human Services Task Force on May 17, 2008.

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Resolution on Medicaid Funding Through a Federal Block Grant

WHEREAS, Total U.S. Medicaid spending in 2006 exceeded $303 billion; and

WHEREAS, The share of federal Medicaid funding provided to the states is determined by a state-by-state matching percentage, and the actual amount of federal funding sent to the states is determined by how much the states spend in order to get those matching dollars; and

WHEREAS, Medicaid policy is also heavily controlled by the federal government, requiring states to apply for waivers if they want the flexibility to reform their Medicaid programs to better meet state needs; and

WHEREAS, States are encouraged to expand Medicaid programs and spend more to get additional funding. The U.S. Government Accountability Office projects that Medicaid spending will grow by 224 percent between 2007 and 2032, and at the same time Medicare and Social Security will put significant pressure on the federal budget; and

WHEREAS, These cost trends and projections for Medicaid, Medicare, and Social Security are unsustainable and will likely lead to difficult cost shifting from the federal government to the states in the Medicaid program, with the result that states will struggle to support their individual Medicaid programs without meaningful control over the policy; and

WHEREAS, Current Medicaid funding arrangements fail to reward states based on performance, but give states additional funding based on outright government appropriations; and

WHEREAS, Medicaid growth is fueled by an interest in gaining additional federal funding, which also makes reductions in state Medicaid spending more difficult due to the additional loss of federal funding; and

WHEREAS, Welfare reform changed the way states managed welfare programs by giving states more policy control and performance expectations, with a fixed amount of money each year; and

WHEREAS, Because welfare reform has proven to be a success since its passage more than ten years ago, states should ask for a similar arrangement with Medicaid that would give states more policy flexibility, fixed state funding, and broad performance goals; and

WHEREAS, Federal funding for the State Children's Health Insurance Program (SCHIP) is allocated to states based on a matching rate up to a total fixed amount of federal funding determined by state need, so there is clear precedent for giving states greater latitude in setting eligibility standards and a fixed amount of funding for similar programs.

THEREFORE BE IT RESOLVED THAT {Insert legislative body} believes that **{insert state}** is best suited to make decisions on Medicaid policy for the residents of this state,

including prioritizing state Medicaid spending to reflect the unique needs of **{insert state}**, and setting eligibility standards that reflect state priorities.

BE IT FURTHER RESOLVED THAT {Insert legislative body} believes that a federal block grant for Medicaid funding would give states greater flexibility to manage the state Medicaid budget and tailor the program to meet state objectives.

BE IT FURTHER RESOLVED THAT Copies of this resolution be sent to the President of the United States, the United States Congress, and the appropriate leadership of the United States Department of Health and Human Services.

Approved by the Health and Human Services Task Force on May 17, 2008. Approved by ALEC Board of Directors on September 11, 2008.

SCHIP Anti-Crowd-Out Act

Model Legislation

Section 1. Short Title. This Act shall be known as the "SCHIP Anti-Crowd-Out Act."

Section 2. Requirement Regarding Employer-Sponsored Coverage.
A. Subject to this Section, no payment may be made under the State Children's Health Insurance Program (SCHIP) with respect to an individual who is eligible for coverage under a group health plan or health insurance coverage offered through an employer, either as an individual or as part of family coverage.

Section 3. Option to Offer Premium Assistance for High-Cost Plans.
A. In the case of an individual who is otherwise eligible for coverage under SCHIP but for the application of Section 2, and who has access to high-cost health insurance coverage, the **{insert state}** will offer a premium assistance subsidy for such coverage.

B. The amount of a premium assistance subsidy under this Section shall be the lesser of:

1. An amount equal to the value of SCHIP coverage that would otherwise apply with respect to the individual or family but for the application of Section 2; or

2. An amount equal to the difference between:

a. The amount of the employee's share of the premium for the high-cost health insurance coverage for the individual or family; and

b. An amount equal to **{insert percentage}** of the total premium amount which includes both the employer and employee share.

Section 4. Definitions. As used in this Act, the following definition applies:

A. "High-cost health insurance coverage" means a group health plan or health insurance coverage offered through an employer in which the employee is required to pay more than 20 percent of the total premium cost.

Section 5. {Severability Clause.}

Section 6. {Repealer Clause.}

Section 7. {Effective Date.}

Approved by the Health and Human Services Task Force on May 17, 2008.

Taking the Best: ALEC's Comprehensive Medical Liability Reform Proposal

Summary

The following is ALEC's summary to accompany *Taking the Best*. Some of the section descriptions are longer because of the length of the Section. All Section summaries indicate the state or source which supplied the suggested language.

Section 1 on Short Title, **Section 2** on Purpose and **Section 3** on Applicability and Scope is self-explanatory.

(Drafting Note: Sections 4-8 may be extracted and used as a stand-alone model bill.)

Section 4 on Limitation of Damage Awards is focused on the awarding of exemplary damages. The cap does not apply in case of specific felonies. The language comes from Texas statutes. Section 18 addresses the limitation on punitive damages.

Section 5 on Further Limitation of Damage Awards is focused on placing a $250,000 no exceptions cap on the awarding of noneconomic damages. Definitions for noneconomic damages, health care provider and professional negligence are provided. The language comes from California statutes.

Section 6 on Periodic Payment of Future Damages is focused on damage awards exceeding $50,000. Either party is allowed to request such an order from the court. If the plaintiff dies, the court must modify the future economic damage award. Damages for future loss of earnings cannot be reduced because of the plaintiff's death. There is legislative intent language on authorizing the entry of judgments through the periodic payment of future damages. The language comes from California statutes.

Section 7 on Collateral Source is focused on using the evidentiary standard to prevent "double dipping". Both the plaintiff and defendant can offer evidentiary evidence to prove receipt of benefits or to prove costs to secure those benefits. The drafting note recognizes alternative language on subrogation based upon a state's law on permitting or prohibiting subrogation. Using the California statutes, there are definitions for a health care provider and for professional negligence.

Section 8 on Contingency Fee Schedule applies whether the recovery is based upon a settlement, arbitration or judgment. The drafting note points out the alternative approaches are based on California or Florida statutes. Either alternative allows the plaintiff attorney to be reimbursed for all reasonable expenses. In California, an award of

one million dollars allows the plaintiff attorney to receive a contingency fee of $221,000 in addition to payment for all reasonable expenses.

Section 9 on Establishment of an Alternative Dispute Resolution System language comes from Texas statutes.

Section 10 on Alternative Dispute Resolution with (or without) Contract contains a drafting note which indicates two alternatives. The first alternative mandates the process. The second alternative allows for the process to be voluntary. In the voluntary alternative, there is no requirement that the medical malpractice claim be arbitrated prior to litigation. This voluntary language comes from California statutes. Most courts require some effort for both parties to enter into a mediation process prior to going to trial. Some medical liability carriers prefer the voluntary process over a mandatory process.

Section 11 on a Medical Review Panel, Certificate of Merit procedure and a Pre-Litigation Medical Screening and Mediation Panel sets forth three alternatives as discussed in the drafting note. The Medical Review Panel language comes from Louisiana statutes. One of its designs is to eliminate frivolous lawsuits. The Certificate of Merit procedure language was developed by The Doctors Company based upon current statutes in various states. The Pre-Litigation Medical Screening and Mediation Panel language comes from Maine statutes. There is a drafting note on the definition of a "qualified medical specialist" in order to ensure that the current definition of a "health care provider" is included in the "qualified medical specialist" definition. Whether one or more of the alternatives are included in proposed legislation, it should be recognized that there will be ongoing administrative costs to institute the alternatives. It is expected that these increased annual costs will be offset by savings from instituting any of the alternatives.

Section 12 on Notice of Intent focuses on the need for the plaintiff to provide a ninety-day notice to bring a medical malpractice civil lawsuit. This language comes from California statutes.

Section 13 on Expert Witness Standards contains a drafting note which recognizes that the location of the medical treatment can have a direct bearing on the residency of the expert witness. This is prevalent in states where a significant portion of the population seeks medical treatment just beyond the state's border. This language comes from Texas and Alabama statutes. There is an evolving national standard of care and application in various treatment modalities. This is especially true in emergency room versus non-emergency room settings. Language on the uniqueness of medical treatment by emergency room physicians comes from California statutes.

Section 14 on Statute of Limitations requires an action be brought within two years after the injury becomes reasonably ascertainable, but not more than four years can elapse. The section recognizes the plaintiff's status as either a minor, being incapacitated, or

imprisoned. Wrongful death actions are dealt with, as well. The language comes from Kansas statutes.

Section 15 on Joint and Several Liability focuses on its abolition. A defendant is only severally liable for the entire amount of the plaintiff's damages equal to the percentage of fault. The section contains definitions for "Acting in concert" and for "Fault". The language comes from Arizona statutes.

Section 16 on Immunities: State Sovereign and Emergency Care Provisions do not contain specific language from various state statutes. Instead, the drafting note recognizes that if immunity provisions are to be included in legislation, the states of Alaska, Florida, Nevada, Oklahoma and Virginia have enacted various immunity provisions for state and local governments and for the providing of emergency medical care. Immunity for a charitable entity recognizes that it could provide both charitable medical services and donated medical products. The drafting note indicates that further clarification can be sought from the American Legislative Exchange Counsel's model legislation on "Good Samaritan" care.

Section 17 on Pre-Judgment Interest Calculations specifies the rate as equal to two percentage points above the 26-week U.S. Treasury Bill rate. The pre-judgment interest accrues from the time of the loss and is paid upon the entire jury verdict award. The language comes from Washington statutes.

Section 18 on Limitation of Punitive Damages contains a drafting note which states that an alternative to a "hard" cap can be found by utilizing the American Legislative Exchange Council's Constitutional Guidelines on Punitive Damages Act. This alternative would enact the U.S. Supreme Court's decision establishing guideposts for courts to follow in determining the excessiveness of a punitive damage award. The section's language comes from North Carolina statutes.

Section 19 on Comparative and Contributory Negligence provides two alternatives as set forth in the drafting note. Modified comparative negligence means that the plaintiff's recovery is barred if his or her negligence exceeds the combined negligence of all the defendants. A pure form of comparative negligence means that the plaintiff's award is reduced in proportion to his or her relative degree of fault. A court or jury has discretion to bar a plaintiff's recovery if the plaintiff willfully or wantonly caused or contributed to the death or to the injury. The language on modified comparative negligence comes from Connecticut statutes and the legal doctrines of last chance and assumption of risk are abolished. The language on pure comparative negligence contains definitions for "economic" and "noneconomic" damages, and "recoverable economic" and "recoverable noneconomic" damages. The alternative language comes from the Arizona statutes.

Section 20 on Ostensible Agency contains a cap on recoverable damages. The language comes from Indiana statutes. A drafting note sets forth two alternatives allowing for a state's case and statutes to be reviewed on the issue of vicarious liability. The liability revolves around the status of being an independent contractor.

Section 21 on "I'm Sorry" language applies where the patient and/or family learns of the circumstances surrounding the injury. All "I'm sorry" statements, affirmations, gestures, or conduct expressing apology, sympathy, fault, etc. are inadmissible as evidence of an admission of liability or as evidence of an admission against interest. There are definitions for "relative", "representative" and "gestures". All of the language, except for the definition of "gestures" comes from Oklahoma statutes. The "gesture" definition was developed by The Doctors Company from applicable state statutes. The meaning of "fault" comes from statutes in Washington, Arizona, South Carolina, and Colorado.

Section 22 on Right of Contribution provides that all joint defendants have a right of contribution in medical malpractice civil actions. The language comes from Texas statutes.

Section 23 on Burden of Proof requires the proof to be clear, cogent and convincing evidence when the plaintiff has signed an informed consent form. The language comes from California statutes.

Section 24 on Definitions provides a definition for the terms "Claimant," "Health Care Goods or Services," and "Health Care Institution." These terms are used either explicitly or implicitly in the *Taking the Best*'s language and in medical liability claims and litigation.

Section 25 provides absolute immunity from liability for a health care provider, which includes a pharmacist in the prescription of medicine, and for a health care institution that volunteer their services without compensation during declared states of emergency, including an executive order, by any man-made, natural, or war-caused event. The language comes from the statutes of Delaware, Florida, and Louisiana.

Section 26 on Appeal from an Interlocutory Order outlines provisions under which a person may appeal from an interlocutory order of a district court, and allows a person to seek an appeal from an interlocutory order of a lower court in a medical litigation proceeding. The language is taken from Texas' 2003 comprehensive tort reform law.

Section 27 on Standards of Proof in Cases Involving Emergency Care deals with the standard of proof necessary to show medical negligence in emergency care situations. The language is taken from Texas' 2003 comprehensive tort reform law.

Section 28 on Severability is self explanatory.

Section 29 on Repealer is self explanatory.

Section 30 on Effective Date provides that the model act's provisions become effective upon signature by the state's governor. This is intended to provide immediate relief for those experiences a state's medical malpractice.

Table of Contents

Section 1. Short Title. This Act may be referred to as "**{insert state}**'s Comprehensive Medical Liability Reform Act."

Section 2. Purpose. The purpose of "**{insert state}**'s Comprehensive Medical Liability Reform Act" is to address the rising cost of medical malpractice insurance that is imposing serious problems for **{insert state}**'s health care system, threatening to curtail the availability of medical care in portions of **{insert state}**, creating a very real possibility that many health care providers will practice without insurance coverage, and leaving patients who might be insured by these health care providers with the prospect of uncollectible judgments.

Section 3. Applicability and Scope. This Act applies to {insert state}'s medical liability system.

(Drafting Note: Sections 4-8 may be extracted and used as a stand-alone model bill.)

Section 4. Limitation of Damage Awards.

A. In an action in which a claimant seeks recovery of damages, the trier of fact shall determine the amount of economic damages separately from the amount of other compensatory damages.

B. Exemplary damages awarded against a defendant may not exceed an amount equal to the greater of:

1. Two times the amount of economic damages; plus

2. An amount equal to any noneconomic damages found by the jury, not to exceed $750,000; or

3. $200,000.

C. This section does not apply to a cause of action against a defendant from whom a plaintiff seeks recovery of exemplary damages based on conduct described as a felony in the following sections of the Penal Code if, except for Section **{insert section}** and Section **{insert section}**, the conduct was committed knowingly or intentionally:

1. Section **{insert section}** (murder);

2. Section **{insert section}** (capital murder);

3. Section **{insert section}** (aggravated kidnapping);

4. Section **{insert section}** (aggravated assault);

5. Section **{insert section}** (sexual assault);

6. Section **{insert section}** (aggravated sexual assault);

7. Section **{insert section}** (injury to a child, elderly individual, or disabled individual, but not if the conduct occurred while providing health care as defined by Section **{insert section}**);

8. Section **{insert section}** (forgery);

9. Section **{insert section}** (commercial bribery);

10. Section **{insert section}** (misapplication of fiduciary property or property of financial institution);

11. Section **{insert section}** (securing execution of document by deception);

12. Section **{insert section}** (fraudulent destruction, removal, or concealment of writing);

13. Section **{insert section}** (theft, the punishment level for which is a felony of the **{insert degree}** degree or higher;

14. Section **{insert section}** (intoxication assault); or

15. Section **{insert section}** (intoxication manslaughter).

D. In this section, "intentionally" and "knowingly" have the same meanings assigned those terms in Sections **{insert sections}** of the Penal Code.

E. The provisions of this section may not be made known to a jury by any means, including voir dire, introduction into evidence, argument, or instruction.

F. This section does not apply to a cause of action for damages arising from the manufacture of methamphetamine as described by Section **{insert section}**.

Section 5. Further Limitation of Damage Awards.

A. In any action for injury against a health care provider based on professional negligence, the injured plaintiff shall be entitled to recover noneconomic losses to compensate for pain, suffering, inconvenience, physical impairment, disfigurement and other nonpecuniary damage.

B. In no action shall the amount of damages for noneconomic losses exceed two hundred fifty thousand dollars ($250,000).

C. The following definitions apply, as used in this Section:

1. "Health care provider" means any person licensed or certified pursuant to Section **{insert section}** or licensed pursuant to **{insert applicable section or licensing directive}**, and any clinic, health dispensary, or health facility, licensed pursuant to Section {insert section}of the Health and Safety Code. "Health care provider" includes the legal representatives of a health care provider.

2. "Professional negligence" means a negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that such services are within the scope of services for which the provider is licensed and

which are not within any restriction imposed by the licensing agency or licensed hospital.

Section 6. Periodic Payments of Future Damages.

A. In any action for injury or damages against a provider of health care services, a superior court shall, at the request of either party, enter a judgment ordering that money damages or its equivalent for future damages of the judgment creditor be paid in whole or in part by periodic payments rather than by a lump-sum payment if the award equals or exceeds fifty thousand dollars ($50,000) in future damages. In entering a judgment ordering the payment of future damages by periodic payments, the court shall make a specific finding as to the dollar amount of periodic payments which will compensate the judgment creditor for such future damages. As a condition to authorizing periodic payments of future damages, the court shall require the judgment debtor who is not adequately insured to post security adequate to assure full payment of such damages awarded by the judgment. Upon termination of periodic payments of future damages, the court shall order the return of this security, or so much as remains, to the judgment debtor.

B.

1. The judgment ordering the payment of future damages by periodic payments shall specify the recipient or recipients of the payments, the dollar amount of the payments, the interval between payments, and the number of payments or the period of time over which payments shall be made. Such payments shall only be subject to modification in the event of the death of the judgment creditor.

2. In the event that the court finds that the judgment debtor has exhibited a continuing pattern of failing to make the payments, as specified in Paragraph 1, the court shall find the judgment debtor in contempt of court and, in addition to the required periodic payments, shall order the judgment debtor to pay the judgment creditor all damages caused by the failure to make such periodic payments, including court costs and attorney's fees.

C. However, money damages awarded for loss of future earnings shall not be reduced or payments terminated by reason of the death of the judgment creditor, but shall be paid to persons to whom the judgment creditor owed a duty of support, as provided by law, immediately prior to his death. In such cases the court which rendered the original judgment, may, upon petition of any party in interest, modify the judgment to award and apportion the unpaid future damages in accordance with this subdivision.

D. Following the occurrence or expiration of all obligations specified in the periodic payment judgment, any obligation of the judgment debtor to make further payments shall cease and any security given, pursuant to Paragraph A shall revert to the judgment debtor.

E. The following definitions apply, as used in this Section:

1. "Future damages" includes damages for future medical treatment, care or custody, loss of future earnings, loss of bodily function, or future pain and suffering of the judgment creditor.

2. "Periodic payments" means the payment of money or delivery of other property to the judgment creditor at regular intervals.

3. "Health care provider" means any person licensed or certified pursuant to Section **{insert section}** or licensed pursuant to **{insert applicable section or licensing directive}**, and any clinic, health dispensary, or health facility, licensed pursuant to Section **{insert section}**of the Health and Safety Code. "Health care provider" includes the legal representatives of a health care provider.

4. "Professional negligence" means a negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that such services are within the scope of services for which the provider is licensed and which are not within any restriction imposed by the licensing agency or licensed hospital.

F. It is the intent of the Legislature in enacting this section to authorize the entry of judgments in malpractice actions against health care providers which provide for the payment of future damages through periodic payments rather than lump-sum payments. By authorizing periodic payment judgments, it is the further intent of the Legislature that the courts will utilize such judgments to provide compensation sufficient to meet the needs of an injured plaintiff and those persons who are dependent on the plaintiff for whatever period is necessary while eliminating the potential windfall from a lump-sum recovery which was intended to provide for the care of an injured plaintiff over an extended period who then dies shortly after the judgment is paid, leaving the balance of the judgment award to persons and purposes for which it was not intended. It is also the intent of the Legislature that all elements of the periodic payment program be specified with certainty in the judgment ordering such payments and that the judgment not be subject to modification at some future time which might alter the specifications of the original judgment.

Section 7. Collateral Source.

(Drafting Note: Some states permit third-party payors to seek reimbursement from a plaintiff or subrogate against a defendant for benefits paid to the plaintiff. In those states, either the legislature or courts have determined that it is appropriate to allow such payors to seek reimbursement or subrogate where a defendant is found negligent in providing medical care. Further, under some circumstances, the defendant's negligent acts gave rise to the payment of benefits by the third party that would not have otherwise been payable. The next paragraph is only appropriate in those states that have already prohibited reimbursement or subrogation.)

A. In the event the defendant so elects, in an action for personal injury against a health care provider based upon professional negligence, he may introduce evidence of any amount payable as a benefit to the plaintiff as a result of the personal injury pursuant to the United States Social Security Act, any state or federal income disability or worker's compensation act, any health, sickness or income-disability insurance, accident insurance that provides health benefits or income-disability coverage, and any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or other health care services. Where the defendant elects to introduce such evidence, the plaintiff may introduce evidence of any amount which the plaintiff has paid or contributed to secure his right to any insurance benefits concerning which the defendant has introduced evidence.

In the event the defendant so elects, in an action for personal injury against a health care provider. No source of collateral benefits introduced pursuant to Paragraph A shall recover any amount against the plaintiff nor shall it be subrogated to the rights of the plaintiff against a defendant.

As provided under Section **{insert section}**, no source of collateral benefits shall recover any amount against the plaintiff nor shall it be subrogated to the rights of the plaintiff against the defendant.

B. The following definitions apply, as used in this Section:

1. "Health care provider" means any person licensed or certified pursuant to Section **{insert section}** or licensed pursuant to **{insert applicable section or licensing directive}**, and any clinic, health dispensary, or health facility, licensed pursuant to Section **{insert section}**of the Health and Safety Code. "Health care provider" includes the legal representatives of a health care provider.

2. "Professional negligence" means a negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that such services are within the scope of services for which the provider is licensed and which are not within any restriction imposed by the licensing agency or licensed hospital.

Section 8. Contingency Fee Schedule.

(Drafting Note: There are two alternatives to include in this Section. Paragraph A1 outlines California's contingency fee schedule. Paragraph A2 outlines Florida's contingency fee schedule.)

A1. An attorney shall not contract for or collect a contingency fee for representing any person seeking damages in connection with an action for injury or damage against a health care provider based upon such person's alleged professional negligence in excess of the following limits:

1. Forty percent of the first fifty thousand dollars ($50,000) recovered.

2. Thirty-three and one-third percent of the next fifty thousand dollars ($50,000) recovered.

3. Twenty-five percent of the next five hundred thousand dollars ($500,000) recovered.

The limitations shall apply regardless of whether the recovery is by settlement, arbitration, or judgment, or whether the person for whom the recovery is made is a responsible adult, an infant, or a person of unsound mind.

A2. In any medical liability claim involving a contingency fee, the claimant is entitled to receive no less than 70% of the first $250,000.00 in all damages received by the claimant, exclusive of reasonable and customary costs, whether received by judgment, settlement, or otherwise, and regardless of the number of defendants. The claimant is entitled to 90% of all damages in excess of $250,000.00, exclusive of reasonable and customary costs and regardless of the number of defendants. This provision is self-executing and does not require implementing legislation.

B. If periodic payments are awarded to the plaintiff pursuant to Section **{insert section}** of the Code of Civil Procedure, the court shall place a total value on these payments based upon the projected life expectancy of the plaintiff and include this amount in computing the total award from which attorney's fees are calculated under this Section.

C. The following definitions apply, as used in this Section:

1. "Recovered" means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim. Costs of medical care incurred by the plaintiff and the attorney's office-overhead costs or charges are not deductible disbursements or costs for such purpose.

2. "Health care provider" means any person licensed or certified pursuant to Section **{insert section}** or licensed pursuant to **{insert applicable section or licensing directive}**, and any clinic, health dispensary, or health facility, licensed pursuant to Section **{insert section}**of the Health and Safety Code. "Health care provider" includes the legal representatives of a health care provider.

3. "Professional negligence" is a negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that the services are within the scope of services for which the provider is licensed and which are not within any restriction imposed by the licensing agency or licensed hospital.

Section 9. Establishment of an Alternative Dispute Resolution System.

A. The commissioners court of a **{insert level of government that administers the court system}** county by order may establish an alternative dispute resolution system for the peaceable and expeditious resolution of citizen disputes.

B. The commissioners court may do all necessary acts to make the alternative dispute resolution system effective, including:

1. Contracting with a private nonprofit corporation, a political subdivision, a public corporation, or a combination of these entities for the purpose of administering the system;

2. Making reasonable rules relating to the system; and

3. Vesting management of the system in a committee selected by the county bar association.

C. The actions of a committee authorized by Paragraph B, Subsection 3 are subject to the approval of the commissioners court.

A judge of a district court, county court, statutory county court, probate court, or justice of the peace court in a county in which an alternative dispute resolution system has been established may, on motion of a party or on the judge's or justice's own motion, refer a case to the system. Referral under this section does not prejudice the case.

D. The following definition applies, as used in this Section:

1. "Alternative dispute resolution system" means an informal forum in which mediation, conciliation, or arbitration is used to resolve disputes among individuals, including those having an ongoing relationship such as relatives, neighbors, landlords and tenants, employees and employers, and merchants and consumers.

Section 10. Alternative Dispute Resolution with (or without) Contract.
(Drafting Note: There are two alternatives to include in this Section. Paragraph A1 mandates the alternative dispute resolution process. Paragraphs A2-F2 allow for voluntary alternative dispute resolution with contract.)

A1. In any action for injury or damages against a provider of health care services, it is mandatory that the plaintiff must first enter into an alternative dispute resolution process before litigation.

A2. Any contract for medical services which contains a provision for arbitration of any dispute as to professional negligence of a health care provider shall have such provision as the first article of the contract and shall be expressed in the following language:

"It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by **{insert state}** law, and not by a lawsuit or resort to court process except as **{insert state}** law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration."

B2. Immediately before the signature line provided for the individual contracting for the medical services must appear the following in at least 10- point bold red type:

"NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT."

C2. Once signed, such a contract governs all subsequent open-book account transactions for medical services for which the contract was signed until or unless rescinded by written notice within 30 days of signature. Written notice of such rescission may be given by a guardian or conservator of the patient if the patient is incapacitated or a minor.

D2. Where the contract is one for medical services to a minor, it shall not be subject to disaffirmance if signed by the minor's parent or legal guardian.

E2. Such a contract is not a contract of adhesion, nor unconscionable nor otherwise improper, where it complies with Paragraphs A, B, and C of this Section.

F2. Paragraphs A, B, and C shall not apply to any health care service plan contract offered by an organization registered pursuant to Section **{insert section}** of the Government Code, or licensed pursuant to Section **{insert section}** of the Health and Safety Code, which contains an arbitration agreement if the plan complies with Section **{insert section}** of the Health and Safety Code, or otherwise has a procedure for notifying prospective subscribers of the fact that the plan has an arbitration provision, and the plan contracts conform to Section **{insert section}** of the Health and Safety Code.

G. The following definitions apply, as used in this Section:

1. "Health care provider" means any person licensed or certified pursuant to Section **{insert section}** or licensed pursuant to **{insert applicable section or licensing directive}**, and any clinic, health dispensary, or health facility, licensed pursuant to Section {insert section}of the Health and Safety Code. "Health care provider" includes the legal representatives of a health care provider.

2. "Professional negligence" means a negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is

the proximate cause of a personal injury or wrongful death, provided that such services are within the scope of services for which the provider is licensed and which are not within any restriction imposed by the licensing agency or licensed hospital.

Section 11. Medical Review Panel/Certificate of Merit/Pre-Litigation Medical Screening and Mediation Panel.

(Drafting Note: There are three alternatives to include in this Section. Paragraphs A1-AO1 outline the establishment of a Medical Review Panel. Paragraphs A2-E2 and Paragraphs A3-D3 include options for Certificate of Merit and Pre-Litigation Medical Screening and Mediation Panels, if the Medical Review Panel's findings are not admissible in court.)

A1. All malpractice claims against health care providers covered by this Section, other than claims validly agreed for submission to a lawfully binding arbitration procedure, shall be reviewed by a medical review panel established as hereinafter provided for in this Section. The filing of a request for review by a medical review panel as provided for in this Section shall not be reportable by any health care provider, the **{insert state}** Patient's Compensation Fund, or any other entity to the **{insert state}** State Board of Medical Examiners, to any licensing authority, committee, or board of any other state, or to any credentialing or similar agency, committee, or board of any clinic, hospital, health insurer, or managed care company.

B1. A request for review of a malpractice claim or malpractice complaint shall contain, at a minimum, all of the following:

1. A request for the formation of a medical review panel.

2. The name of the patient.

3. The names of the claimants.

4. The names of defendant health care providers.

5. The dates of the alleged malpractice.

6. A brief description of the alleged malpractice as to each named defendant state health care provider.

7. A brief description of alleged injuries.

C1. A claimant shall have forty-five days from the mailing date of the confirmation of receipt of the request for review in accordance with this Section to pay to the board a filing fee in the amount of one hundred dollars per named defendant qualified under this Section.

D1. Such filing fee may be waived only upon receipt of one of the following:

1. An affidavit of a physician holding a valid and unrestricted license to practice his specialty in the state of his residence certifying that adequate medical records have been obtained and reviewed and that the allegations of malpractice against each defendant health care provider named in the claim constitute a claim of a breach of the applicable standard of care as to each named defendant health care provider.

2. An in forma pauperis ruling issued in accordance with **{insert code section}** by a district court in a venue in which the malpractice claim could properly be brought upon the conclusion of the medical review panel process.

E1. Failure to comply with the provisions of this Section within the specified time frame shall render the request for review of a malpractice claim invalid and without effect. Such an invalid request for review of a malpractice claim shall not suspend the time within which suit must be instituted in this Section.

F1. All funds generated by such filing fees shall be private monies and shall be applied to the costs of the Patient's Compensation Fund Oversight Board incurred in the administration of claims.

G1. The filing fee of one hundred dollars per named defendant qualified under this Section shall be applicable in the event that a claimant identifies additional qualified health care providers as defendants. The filing fee applicable to each identified qualified health care provider shall be due forty-five days from the mailing date of the confirmation of receipt of the request for review for the additional named defendants in accordance with **{insert section}**.

H1. The filing of the request for a review of a claim shall suspend the time within which suit must be instituted, in accordance with this Section, until ninety days following notification, by certified mail, as provided in this Section, to the claimant or his attorney of the issuance of the opinion by the medical review panel, in the case of those health care providers covered by this Section, or in the case of a health care provider against whom a claim has been filed under the provisions of this Section, but who has not qualified under this Section, until sixty days following notification by certified mail to the claimant or his attorney by the board that the health care provider is not covered by this Section. The filing of a request for review of a claim shall suspend the running of prescription against all joint and solidary obligors, and all joint tortfeasors, including but not limited to health care providers, both qualified and not qualified, to the same extent that prescription is suspended against the party or parties that are the subject of the request for review. Filing a request for review of a malpractice claim as required by this Section with any agency or entity other than the division of administration shall not suspend or interrupt the running of prescription. All requests for review of a malpractice claim identifying additional health care providers shall also be filed with the division of administration.

I1. The request for review of a malpractice claim under this Section shall be deemed filed on the date of receipt of the request stamped and certified by the division of administration or on the date of mailing of the request if mailed to the division of administration by certified or registered mail only upon timely compliance with the provisions of this Section. Upon receipt of any request, the division of administration shall forward a copy of the request to the board within five days of receipt.

J1. An attorney chairman for the medical review panel shall be appointed within one year from the date the request for review of the claim was filed. Upon appointment of the attorney chairman, the parties shall notify the board of the name and address of the attorney chairman. If the board has not received notice of the appointment of an attorney chairman within nine months from the date the request for review of the claim was filed, then the board shall send notice to the parties by certified or registered mail that the claim will be dismissed in ninety days unless an attorney chairman is appointed within one year from the date the request for review of the claim was filed. If the board has not received notice of the appointment of an attorney chairman within one year from the date the request for review of the claim was filed, then the board shall promptly send notice to the parties by certified or registered mail that the claim has been dismissed for failure to appoint an attorney chairman and the parties shall be deemed to have waived the use of the medical review panel. The filing of a request for a medical review panel shall suspend the time within which suit must be filed until ninety days after the claim has been dismissed in accordance with this Section.

K1. It shall be the duty of the board within fifteen days of the receipt of the claim by the board to:

1. Confirm to the claimant that the filing has been officially received and whether or not the named defendant or defendants have qualified under this Section.

2. In the confirmation to the claimant pursuant to this Section, notify the claimant of the amount of the filing fee due and the time frame within which such fee is due to the board, and that upon failure to comply with the provisions of this Section, the request for review of a malpractice claim is invalid and without effect and that the request shall not suspend the time within which suit must be instituted in this Section.

L1. Notify all named defendants, whether or not qualified under the provisions of this Section, that a filing has been made against them and request made for the formation of a medical review panel; and forward a copy of the proposed complaint to each named defendant at his last and usual place of residence or his office.

M1. The board shall notify the claimant and all named defendants by registered or certified mail, return receipt requested, of any of the following information:

1. The date of receipt of the filing fee.

2. That no filing was due because the claimant timely provided the affidavit set forth in this Section.

3. That the claimant has timely complied with the provisions of this Section.

4. That the required filing fee was not timely paid pursuant to this Section.

N1. No action against a health care provider covered by this Section, or his insurer, may be commenced in any court before the claimant's proposed complaint has been presented to a medical review panel established pursuant to this Section.

O1. A certificate of enrollment issued by the board shall be admitted in evidence. However, with respect to an act of malpractice which occurs after **{insert date}**, if an opinion is not rendered by the panel within twelve months after the date of notification of the selection of the attorney chairman by the executive director to the selected attorney and all other parties pursuant to this Section, suit may be instituted against a health care provider covered by this Section. However, either party may petition a court of competent jurisdiction for an order extending the twelve-month period provided in this Section for good cause shown. After the twelve month period provided for in this Section or any court-ordered extension thereof, the medical review panel established to review the claimant's complaint shall be dissolved without the necessity of obtaining a court order of dissolution. By agreement of both parties, the use of the medical review panel may be waived.

P1. A health care provider, against whom a claim has been filed under the provisions of this Section, may raise any exception or defenses available pursuant to **{insert section}** in a court of competent jurisdiction and proper venue at any time without need for completion of the review process by the medical review panel.

Q1. If the court finds that the claim had prescribed or otherwise was preempted prior to being filed, the panel, if established, shall be dissolved. Ninety days after the notification to all parties by certified mail by the attorney chairman of the board of the dissolution of the medical review panel or ninety days after the expiration of any court-ordered extension as authorized by this Section, the suspension of the running of prescription with respect to a qualified health care provider shall cease.

R1. The medical review panel shall consist of three health care providers who hold unlimited licenses to practice their profession in **{insert state}** and one attorney. The parties may agree on the attorney member of the medical review panel. If no attorney for or representative of any health care provider named in the complaint has made an appearance in the proceedings or made written contact with the attorney for the plaintiff within forty-five days of the date of receipt of the notification to the health care provider and the insurer that the required filing fee has been received by the patient's compensation board as required by **{insert section}** the attorney for the plaintiff may appoint the attorney member of the medical review panel for the purpose of convening

the panel. Such notice to the health care provider and the insurer shall be sent by registered or certified mail, return receipt requested. If no agreement can be reached, then the attorney member of the medical review panel shall be selected in the following manner:

1. The office of the clerk of the **{insert state}** Supreme Court, upon receipt of notification from the board, shall draw five names at random from the list of attorneys who reside or maintain an office in the **{insert level of government}** which would be proper venue for the action in a court of law. The names of judges, magistrates, district attorneys and assistant district attorneys shall be excluded if drawn and new names drawn in their place. After selection of the attorney names, the office of the clerk of the Supreme Court shall notify the board of the names so selected. It shall be the duty of the board to notify the parties of the attorney names from which the parties may choose the attorney member of the panel within five days. If no agreement can be reached within five days, the parties shall immediately initiate a procedure of selecting the attorney by each striking two names alternately, with the claimant striking first and so advising the health care provider of the name of the attorney so stricken; thereafter, the health care provider and the claimant shall alternately strike until both sides have stricken two names and the remaining name shall be the attorney member of the panel. If either the plaintiff or defendant fails to strike, the clerk of the **{insert state}** Supreme Court shall strike for that party within five additional days.

2. After the striking, the office of the board shall notify the attorney and all other parties of the name of the selected attorney.

3. The attorney shall act as chairman of the panel and in an advisory capacity but shall have no vote. It is the duty of the chairman to expedite the selection of the other panel members, to convene the panel, and expedite the panel's review of the proposed complaint. The chairman shall establish a reasonable schedule for submission of evidence to the medical review panel but must allow sufficient time for the parties to make full and adequate presentation of related facts and authorities within ninety days following selection of the panel.

S1. The plaintiff shall notify the attorney chairman and the named defendants of his choice of a health care provider member of the medical review panel within thirty days of the date of certification of his filing by the board.

1. The named defendant shall then have fifteen days after notification by the plaintiff of the plaintiff's choice of his health care provider panelist to name the defendant's health care provider panelist.

2. If either the plaintiff or defendant fails to make a selection of health care provider panelist within the time provided, the attorney chairman shall notify by

certified mail the failing party to make such selection within five days of the receipt of the notice.

3. If no selection is made within the five day period, then the chairman shall make the selection on behalf of the failing party. The two health care provider panel members selected by the parties or on their behalf shall be notified by the chairman to select the third health care provider panel member within fifteen days of their receipt of such notice.

4. If the two health care provider panel members fail to make such selection within the fifteen day period allowed, the chairman shall then make the selection of the third panel member and thereby complete the panel.

5. A physician who holds an unrestricted license to practice medicine by the **{insert state}** State Board of Medical Examiners and who is engaged in the active practice of medicine in this state, whether in the teaching profession or otherwise, shall be available for selection as a member of a medical review panel.

6. Each party to the action shall have the right to select one health care provider and upon selection the health care provider shall be required to serve.

7. When there are multiple plaintiffs or defendants, there shall be only one health care provider selected per side. The plaintiff, whether single or multiple, shall have the right to select one health care provider, and the defendant, whether single or multiple, shall have the right to select one health care provider.

8. A panelist so selected and the attorney member selected in accordance with this Subsection shall serve unless for good cause shown may be excused. To show good cause for relief from serving, the panelist shall present an affidavit to a judge of a court of competent jurisdiction and proper venue which shall set out the facts showing that service would constitute an unreasonable burden or undue hardship. A health care provider panelist may also be excused from serving by the attorney chairman if during the previous twelve-month period he has been appointed to four other medical review panels. In either such event, a replacement panelist shall be selected within fifteen days in the same manner as the excused panelist.

9. If there is only one party defendant which is not a hospital, community blood center, tissue bank, or ambulance service, all panelists except the attorney shall be from the same class and specialty of practice of health care provider as the defendant. If there is only one party defendant which is a hospital, community blood center, tissue bank, or ambulance service, all panelists except the attorney shall be physicians. If there are claims against multiple defendants, one or more of whom are health care providers other than a hospital, community blood center, tissue bank, or ambulance service, the panelists selected in accordance with this Section may also be selected from health care providers who are from the same

class and specialty of practice of health care providers as are any of the defendants other than a hospital, community blood center, tissue bank, or ambulance service.

T1. When the medical review panel is formed, the chairman shall within five days notify the board and the parties by registered or certified mail of the names and addresses of the panel members and the date on which the last member was selected.

U1. Before entering upon their duties, each voting panelist shall subscribe before a notary public the following oath:

"I, (name) do solemnly swear/affirm that I will faithfully perform the duties of medical review panel member to the best of my ability and without partiality or favoritism of any kind. I acknowledge that I represent neither side and that it is my lawful duty to serve with complete impartiality and to render a decision in accordance with law and the evidence."

The attorney panel member shall subscribe to the same oath except that in lieu of the last sentence thereof the attorney's oath shall state:

"I acknowledge that I represent neither side and that it is my lawful duty to advise the panel members concerning matters of law and procedure and to serve as chairman."

V1. The original of each oath shall be attached to the opinion rendered by the panel.

W1. The party aggrieved by the alleged failure or refusal of another to perform according to the provisions of this Section may petition any district court of proper venue over the parties for an order directing that the parties comply with the medical review panel provisions of the medical malpractice act.

X1. A panelist or a representative or attorney for any interested party shall not discuss with other members of a medical review panel on which he serves a claim which is to be reviewed by the panel until all evidence to be considered by the panel has been submitted. A panelist or a representative or attorney for any interested party shall not discuss the pending claim with the claimant or his attorney asserting the claim or with a health care provider or his attorney against whom a claim has been asserted under this Section. A panelist or the attorney chairman shall disclose in writing to the parties prior to the hearing any employment relationship or financial relationship with the claimant, the health care provider against whom a claim is asserted, or the attorneys representing the claimant or health care provider, or any other relationship that might give rise to a conflict of interest for the panelists.

Y1. The evidence to be considered by the medical review panel shall be promptly submitted by the respective parties in written form only.

1. The evidence may consist of medical charts, x-rays, lab tests, excerpts of treatises, depositions of witnesses including parties, interrogatories, affidavits and reports of medical experts, and any other form of evidence allowable by the medical review panel.

2. Depositions of the parties and witnesses may be taken prior to the convening of the panel.

3. Upon request of any party, or upon request of any two panel members, the clerk of any district court shall issue subpoenas and subpoenas duces tecum in aid of the taking of depositions and the production of documentary evidence for inspection and/or copying.

4. The chairman of the panel shall advise the panel relative to any legal question involved in the review proceeding and shall prepare the opinion of the panel as provided in this Section.

5. A copy of the evidence shall be sent to each member of the panel.

Z1. Either party, after submission of all evidence and upon ten days notice to the other side, shall have the right to convene the panel at a time and place agreeable to the members of the panel. Either party may question the panel concerning any matters relevant to issues to be decided by the panel before the issuance of their report. The chairman of the panel shall preside at all meetings. Meetings shall be informal.

AA1. The panel shall have the right and duty to request and procure all necessary information. The panel may consult with medical authorities, provided the names of such authorities are submitted to the parties with a synopsis of their opinions and provided further that the parties may then obtain their testimony by deposition. The panel may examine reports of such other health care providers necessary to fully inform itself regarding the issue to be decided. Both parties shall have full access to any material submitted to the panel.

AB1. The panel shall have the sole duty to express its expert opinion as to whether or not the evidence supports the conclusion that the defendant or defendants acted or failed to act within the appropriate standards of care. After reviewing all evidence and after any examination of the panel by counsel representing either party, the panel shall, within thirty days but in all events within one hundred eighty days after the selection of the last panel member, render one or more of the following expert opinions, which shall be in writing and signed by the panelists, together with written reasons for their conclusions:

1. The evidence supports the conclusion that the defendant or defendants failed to comply with the appropriate standard of care as charged in the complaint.

2. The evidence does not support the conclusion that the defendant or defendants failed to meet the applicable standard of care as charged in the complaint.

3. That there is a material issue of fact, not requiring expert opinion, bearing on liability for consideration by the court.

4. When this Section is answered in the affirmative, that the conduct complained of was or was not a factor of the resultant damages. If such conduct was a factor, whether the plaintiff suffered:

a) any disability and the extent and duration of the disability, and

b) any permanent impairment and the percentage of the impairment.

AC1. Any report of the expert opinion reached by the medical review panel shall be admissible as evidence in any action subsequently brought by the claimant in a court of law, but such expert opinion shall not be conclusive and either party shall have the right to call, at his cost, any member of the medical review panel as a witness. If called, the witness shall be required to appear and testify. A panelist shall have absolute immunity from civil liability for all communications, findings, opinions and conclusions made in the course and scope of duties prescribed by this Section.

AD1. Each physician member of the medical review panel shall be paid at the rate of twenty-five dollars per diem, not to exceed a total of three hundred dollars for all work performed as a member of the panel exclusive of time involved if called as a witness to testify in a court of law regarding the communications, findings, and conclusions made in the course and scope of duties as a member of the medical review panel, and in addition thereto, reasonable travel expenses.

AE1. The attorney chairman of the medical review panel shall be paid at the rate of one hundred dollars per diem, not to exceed a total of two thousand dollars for all work performed as a member of the panel exclusive of time involved if called as a witness to testify in a court of law regarding the communications, findings, and conclusions made in the course and scope of duties as a member of the medical review panel, and in addition thereto, reasonable travel expenses. Additionally, the attorney chairman shall be reimbursed for all reasonable out-of-pocket expenses incurred in performing his duties for each medical review panel. The attorney chairman shall submit the amount due him for all work performed as a member of the panel by affidavit, which shall attest that he has performed in the capacity of chairman of the medical review panel and that he was personally present at all the panel's meetings or deliberations.

AF1. The costs of the medical review panel shall be paid by the health care provider if the opinion of the medical review panel is in favor of said defendant health care provider.

AG1. The claimant shall pay the costs of the medical review panel if the opinion of the medical review panel is in favor of the claimant. However, if the claimant is unable to pay, the claimant shall submit to the attorney chairman prior to the convening of the medical review panel an in forma pauperis ruling issued in accordance with **{insert state**

and code section} Code of Civil Procedure by a district court in a venue in which the malpractice claim could properly be brought upon the conclusion of the medical review panel process. Upon timely receipt of the in forma pauperis ruling, the costs of the medical review panel shall be paid by the health care provider, with the proviso that if the claimant subsequently receives a settlement or receives a judgment, the advance payment of the medical review panel costs will be offset.

AH1. In a medical malpractice suit filed by the claimant in which a unanimous opinion was rendered in favor of the defendant health care provider as provided in the expert opinion stated in this Section, the claimant who proceeds to file such a suit shall be required to post a cash or surety bond, approved by the court, in the amount of all costs of the medical review panel. Upon the conclusion of the medical malpractice suit, the court shall order that the cash or surety bond be forfeited to the defendant health care provider for reimbursement of the costs of the medical review panel, unless a final judgment is rendered finding the defendant liable to the claimant for any damages. If a final judgment is rendered finding the defendant liable to the claimant for any damages, the court shall order that the defendant health care provider reimburse the claimant an amount equal to the cost of obtaining the cash or surety bond posted by the claimant.

AI1. In the event a medical review panel renders a unanimous opinion in favor of the claimant as provided in the expert opinions stated in this Section, and the claimant has not timely submitted an in forma pauperis ruling to the panel's attorney chairman, and thereafter the defendant health care provider failed to settle the claim with the claimant resulting in the claimant filing a malpractice suit in a court of competent jurisdiction and proper venue against the defendant health care provider based on the same claim which was the subject of the unanimously adverse medical review panel opinion against the defendant health care provider, the defendant health care provider shall be required to post a cash or surety bond, approved by the court, in the amount of all costs of the medical review panel. Upon the conclusion of the medical malpractice suit, the court shall order that the cash or surety bond be forfeited to the claimant for reimbursement of the costs of the medical review panel, unless a final judgment is rendered finding that the defendant health care provider has no liability for damages to the claimant. If a final judgment is rendered finding that the defendant health care provider has no liability for damages to the claimant, the court shall order that the claimant reimburse the defendant health care provider an amount equal to the cost of obtaining the cash or surety bond posted by the defendant health care provider.

AJ1. If the medical review panel decides that there is a material issue of fact bearing on liability for consideration by the court, the claimant and the health care provider shall split the costs of the medical review panel. However, in those instances in which the claimant is unable to pay his share of the costs of the medical review panel, the claimant shall submit to the attorney chairman prior to the convening of the medical review panel an in forma pauperis ruling issued in accordance with **{insert state and code section}** Code of Civil Procedure, by a district court in a venue in which the malpractice claim could properly be brought upon the conclusion of the medical review panel process. Upon timely receipt of the in forma pauperis ruling, the costs of the medical review

panel shall be paid by the defendant health care provider with the proviso that if the claimant subsequently receives a settlement or receives a judgment, the advance payment of the claimant's share of the costs of the medical review panel will be offset.

AK1. Upon the rendering of the written panel decision, if any one of the panelists finds that the evidence supports the conclusion that a defendant health care provider failed to comply with the appropriate standard of care as charged in the complaint, each defendant health care provider as to whom such a determination was made shall reimburse to the claimant that portion of the filing fee applicable to the claim against such defendant health care provider or if any one of the panelists finds that the evidence supports the conclusion that there is a material issue of fact, not requiring expert opinion, bearing on liability of such defendant health care provider for consideration by the court, each such defendant health care provider as to whom such a determination was made shall reimburse to the claimant fifty percent of that portion of the filing fee applicable to the claim against such defendant health care provider.

AL1. The chairman shall submit a copy of the panel's report to the board and all parties and attorneys by registered or certified mail within five days after the panel renders its opinion.

AM1. In the event the medical review panel after a good faith effort has been unable to carry out its duties by the end of the one hundred eighty day period, as provided in **{insert section}** either party or the board, after exhausting all remedies available to them under this Section, may petition the appropriate court of competent jurisdiction for an order to show cause why the panel should not be dissolved and the panelists relieved of their duties. The suspension of the running of prescription shall cease sixty days after the receipt by the claimant or his attorney of the final order dissolving the medical review panel, which order shall be mailed to the claimant or his attorney by certified mail.

AN1. Where the medical review panel issues its opinion after the one hundred eighty days required by this Section, the suspension of the running of prescription shall not cease until ninety days following notification by certified mail to the claimant or his attorney of the issuance of the opinion as required by this Section.

AO1. Legal interest shall accrue from the date of filing of the complaint with the board on a judgment rendered by a court in a suit for medical malpractice brought after compliance with this Section.

A2. Within 30 days of the filing of a health care lawsuit, the court shall appoint a qualified specialist whose appointment is agreed to by one qualified specialist chosen by the claimant and one qualified specialist chosen by the defendant. If a qualified specialist is not agreed to by the qualified specialist chosen by the claimant and the qualified specialist chosen by the defendant within such 30 days, then the court shall appoint such qualified specialist at its discretion. The qualified specialist appointed by the court shall, within 45 days of such appointment, submit to the court an affidavit that includes such specialist's statement of opinion whether, based on a review of the available medical

record and other relevant material, there is a reasonable and meritorious cause for the filing of the action against the defendant. If such specialist does not submit such affidavit to the court within 45 days of such appointment, the court shall dismiss such health care lawsuit. Such affidavit shall also contain a statement by the qualified specialist of specific breaches in the standard of care and the approximate negligence causation. Such affidavit shall not be admissible in any health care lawsuit or other court proceedings, or any arbitration proceeding. However, such affidavit, and information relevant to the determinations made by such specialist in such affidavit, shall be discoverable by the plaintiff and the defendant. In the case of multiple defendants, a separate affidavit shall be required for each defendant. The court shall set a reasonable fee that shall be paid by the claimant for the preparation of such affidavit by such qualified specialist. The plaintiff's attorney shall be given 90 days to obtain the certificate of merit/affidavit in cases where the period to file the claim is due to expire because of the statute of limitations. If a case is filed without a certificate of merit/affidavit, dismissal of the case is automatic without an extension permitted under the applicable statute of limitation exemption provision.

B2. The following definitions apply, as used in this Section:

1. "Qualified specialist" means, with respect to a health care lawsuit—

a) except as required under this Section, a health care professional who—

b) is appropriately credentialed or licensed in one or more states to deliver health care services; and

c) typically treats the diagnosis or condition or provides the type of treatment under review; and

d) can demonstrate by competent evidence that, as a result of training, education, knowledge, and experience in the evaluation, diagnosis, and treatment of the disease or injury which is the subject matter of the lawsuit against the defendant, the individual was substantially familiar with applicable standards of care and practice as they relate to the act or omission which is the subject of the lawsuit on the date of the incident.

C2. In a health care lawsuit, if the claim of the plaintiff involved treatment that is recommended or provided by a physician (allopathic or osteopathic), an individual shall not be a qualified specialist under this Section with respect to issues of negligence concerning such treatment unless such individual is a physician.

(Drafting Note: For purposes of this Section, a "qualified medical specialist" is defined as an individual licensed to provide medical care in a particular specialty.)

D2. An individual shall not be a qualified specialist if such individual's medical specialty or subspecialty is different from the defendant's unless, in addition to a showing

of substantial familiarity in accordance with this Section, there is a showing that the standards of care and practice in the two specialty or subspecialty fields are similar.

E2. In a health care lawsuit, in the event the statement of opinion by a qualified specialist appointed by the court in an affidavit is that there is no reasonable and meritorious cause for the filing of the action against the defendant, and the claimant does not substantially prevail by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution, the court shall order the claimant, or such claimant's attorneys, to pay the costs and reasonable attorneys fees incurred by the defendant as a direct result of the health care lawsuit in which such qualified specialist's opinion was filed. Claimants and their attorneys shall share liability for such costs and reasonable attorneys fees incurred, as determined by the court in the interests of justice.

A3. The purpose of mandatory prelitigation screening and mediation panels is to:

1. Identify claims of professional negligence which merit compensation and to encourage early resolution of those claims prior to commencement of a lawsuit; and

2. To identify claims of professional negligence and to encourage early withdrawal or dismissal of nonmeritorious claims.

B3. Mandatory panel screening procedures for medical malpractice actions pursuant to statute are rationally related to legitimate purpose of expediting resolution of medical liability claims in order to decrease high costs of medical liability insurance, and thus, screening statutes do not violate equal protection clause.

C3. District courts will not have discretion to dismiss supplemental medical negligence claims, where the plaintiff failed to comply with procedural requirements of this Act applicable to negligence claim and retention of jurisdiction through conclusion of pre-litigation screening process would unnecessarily delay resolution of plaintiff's other federal and state claims.

D3. The following definition applies, as used in this Section:

1. "Claim of professional negligence" is limited to any written notice of claim served pursuant to Section **{insert section}** against health care practitioners and health care providers or any employee or agent acting within the scope of their authority.

Section 12. Notice of Intent.

A. A plaintiff must give a ninety-day notice of an intention to bring a civil suit for alleged medical professional negligence. If the notice is given in the 90 days of the expiration of the statute of limitations, the statute is extended 90 days from the date of the notice.

Section 13. Expert Witness Standards.

(Drafting Note: The geographic location of a state within a region can have a direct impact on the location of the medical treatment. It is recognized that there will be instances when the residency of the expert witness will play a significant role in the quality of the testimony and its relevance to how medical treatment is provided at the local level.)

A. To qualify as an expert witness against a physician in a malpractice claim, the witness must be a physician with board certification or other substantial experience relevant to the claim who is practicing or teaching in an area of medicine that is relevant to the claim (or was at the time the claim arose).

B. Within 90 days after filing a notice of claim, a plaintiff must post a bond or file an expert report for each defendant. Within 180 days after filing a notice of claim, a plaintiff must provide to counsel for each defendant physician or health care provider an expert witness report or reports along with a curriculum vitae for each expert.

C. Foreign objects left in the body after surgery or an injury remote from the part of the body that received medical treatment do not require such testimony.

D. An expert witness shall be substantially familiar with applicable evolving national standards of care and practice as they relate to the act or omission which is the subject of the lawsuit on the date of the incident.

E. An expert witness is an individual who typically treats the diagnosis or condition or provides the type of treatment under review.

Section 14. Statute of Limitations.

A. The following actions shall be brought within two years:

1. An action for trespass upon real property.

2. An action for taking, detaining or injuring personal property, including actions for the specific recovery thereof.

3. An action for relief on the ground of fraud, but the cause of action shall not be deemed to have accrued until the fraud is discovered.

4. An action for injury to the rights of another, not arising on contract, and not herein enumerated.

5. An action for wrongful death.

6. An action to recover for an ionizing radiation injury as provided in Sections **{insert sections}** and amendments thereto.

7. An action arising out of the rendering of or failure to render professional services by a health care provider, not arising on contract.

B. Except as provided in Paragraphs C and D, the causes of action listed in Paragraph A shall not be deemed to have accrued until the act giving rise to the cause of action first causes substantial injury, or, if the fact of injury is not reasonably ascertainable until some time after the initial act, then the period of limitation shall not commence until the fact of injury becomes reasonably ascertainable to the injured party, but in no event shall an action be commenced more than 10 years beyond the time of the act giving rise to the cause of action.

C. A cause of action arising out of the rendering of or the failure to render professional services by a health care provider shall be deemed to have accrued at the time of the occurrence of the act giving rise to the cause of action, unless the fact of injury is not reasonably ascertainable until some time after the initial act, then the period of limitation shall not commence until the fact of injury becomes reasonably ascertainable to the injured party, but in no event shall such an action be commenced more than four years beyond the time of the act giving rise to the cause of action.

D. A negligence cause of action by a corporation or association against an officer or director of the corporation or association shall not be deemed to have accrued until the act giving rise to the cause of action first causes substantial injury, or, if the fact of injury is not reasonably ascertainable until some time after the initial act, then the period of limitation shall not commence until the fact of injury becomes reasonably ascertainable to the injured party, but in no event shall such an action be commenced more than five years beyond the time of the act giving rise to the cause of action. All other causes of action by a corporation or association against an officer or director of the corporation or association shall not be deemed to have accrued until the act giving rise to the cause of action first causes substantial injury and there exists a disinterested majority of nonculpable directors of the corporation or association, or, if the fact of injury is not reasonably ascertainable until some time after the initial act, then the period of limitation shall not commence until the fact of injury becomes reasonably ascertainable and there exists a disinterested majority of nonculpable directors of the corporation or association, but in no event shall such an action be commenced more than 10 years beyond the time of the act giving rise to the cause of action.

E. The provisions of this Section as it was constituted prior to **{insert effective date}** shall continue in force and effect for a period of two years from that date with respect to any act giving rise to a cause of action occurring prior to that date.

F. Except as provided in Section **{insert section}**, if any person entitled to bring an action, other than for the recovery of real property or a penalty or a forfeiture, at the time the cause of action accrued or at any time during the period the statute of limitations is running, is less than 18 years of age, an incapacitated person or imprisoned for a term less than such person's natural life, such person shall be entitled to bring such action within one year after the person's disability is removed, except that no such action shall be

commenced by or on behalf of any person under the disability more than eight years after the time of the act giving rise to the cause of action. Notwithstanding the foregoing provision, if a person imprisoned for any term has access to the court for purposes of bringing an action, such person shall not be deemed to be under legal disability.

G. If any person entitled to bring an action dies during the continuance of any disability specified in Paragraph F and no determination is made of the cause of action accrued to the deceased, any person entitled to claim from, by or under the deceased, may commence such action within one year after the deceased's death, but in no event shall any such action be commenced more than eight years beyond the time of the act giving rise to the cause of action.

H. The following definition applies, as used in this Section:

1. "Negligence cause of action" shall not include a cause of action seeking monetary damages for any breach of the officer's or director's duty of loyalty to the corporation or association, for acts or omissions not in good faith or which involve intentional misconduct or a knowing violation of law, for liability under Sections **{insert sections}** and amendments thereto, or for any transaction from which the officer or director derived an improper personal benefit.

Section 15. Joint and Several Liability Provisions.

A. In an action for personal injury, property damage or wrongful death, the liability of each defendant for damages is several only and is not joint, except as otherwise provided in this section. Each defendant is liable only for the amount of damages allocated to that defendant in direct proportion to that defendant's percentage of fault, and a separate judgment shall be entered against the defendant for that amount. To determine the amount of judgment to be entered against each defendant, the trier of fact shall multiply the total amount of damages recoverable by the plaintiff by the percentage of each defendant's fault, and that amount is the maximum recoverable against the defendant.

B. In assessing percentages of fault the trier of fact shall consider the fault of all persons who contributed to the alleged injury, death or damage to property, regardless of whether the person was, or could have been, named as a party to the suit. Negligence or fault of a nonparty may be considered if the plaintiff entered into a settlement agreement with the nonparty or if the defending party gives notice before trial, in accordance with requirements established by court rule, that a nonparty was wholly or partially at fault. Assessments of percentages of fault for nonparties are used only as a vehicle for accurately determining the fault of the named parties. Assessment of fault against nonparties does not subject any nonparty to liability in this or any other action, and it may not be introduced as evidence of liability in any action.

C. The relative degree of fault of the claimant, and the relative degrees of fault of all defendants and nonparties, shall be determined and apportioned as a whole at one time by the trier of fact. If two or more claimants have independent claims, a separate

determination and apportionment of the relative degrees of fault of the respective parties, and any nonparties at fault, shall be made with respect to each of the independent claims.

D. The liability of each defendant is several only and is not joint, except that a party is responsible for the fault of another person, or for payment of the proportionate share of another person, if any of the following applies:

1. Both the party and the other person were acting in concert.

2. The other person was acting as an agent or servant of the party.

3. The party's liability for the fault of another person arises out of a duty created by the federal employers' liability act, 45 United States Code § 51.

E. If a defendant is found jointly and severally liable pursuant to Paragraph D, the defendant has the right to contribution pursuant to this chapter. In an action arising out of a duty created by the federal employers' liability act (45 United States code § 51), a person or entity, other than an employee of the defendant, whose negligence or fault caused or contributed to the plaintiff's injury or death shall contribute to the defendant pursuant to this chapter. An action for contribution shall be adjudicated and determined by the same trier of fact that adjudicates and determines the action for the plaintiff's injury or death. The trier of fact shall adjudicate and determine an action for contribution after the court enters a judgment for the plaintiff's injury or death. On motion before the conclusion of the trial, the plaintiff is entitled to an award against the defendant for actual expenses the plaintiff incurred as a direct result of the defendant's claim for contribution. The expenses shall include reasonable attorney fees as determined by the court.

F. The following definitions apply, as used in this Section:

1. "Acting in concert" means entering into a conscious agreement to pursue a common plan or design to commit an intentional tort and actively taking part in that intentional tort. Acting in concert does not apply to any person whose conduct was negligent in any of its degrees rather than intentional. A person's conduct that provides substantial assistance to one committing an intentional tort does not constitute acting in concert if the person has not consciously agreed with the other to commit the intentional tort.

2. "Fault" means an actionable breach of legal duty, act or omission proximately causing or contributing to injury or damages sustained by a person seeking recovery, including negligence in all of its degrees, contributory negligence, assumption of risk, strict liability, breach of express or implied warranty of a product, products liability and misuse, modification or abuse of a product.

Section 16. Immunities: State Sovereign and Emergency Care Provisions.
(Drafting Note: The states of Alaska, Florida, Nevada, Oklahoma, and Virginia have enacted statutes addressing immunities for state and local governments and for the

providing of emergency medical care. The text below is a summary of what these states have accomplished in this area. For further clarification of this Section, see ALEC's model legislation on "Good Samaritan" care.)

A. State institutions and its employees are only liable for $50,000 in damages exclusive of pre-judgment interest. The damage award cannot include amounts for exemplary or punitive damages. A government entity does not waive its sovereign immunity through the purchase of insurance coverage. A plaintiff must file an action within two years after the cause of action accrued.

B. The state and its academic institutions cannot be sued if the action is based upon an act or omission by a state employee exercising due care in performing a discretionary function or duty.

C. Municipalities are immune in their performance of governmental functions, which includes the operation of a city or county hospital or medical facility.

D. A charitable entity is not liable for negligent acts of its agents, including rendering charitable medical services and/or medical products when they are donations.

E. A plaintiff who obtains an unenforceable judgment above the monetary limit can petition the state legislature for a "claim bill" granting the payment of public monies to pay the amount above the limit.

Section 17. Pre-Judgment Interest Calculations.

A. Interest on an award of damages rendered on a written instrument without a specified interest rate shall be calculated for the period of time elapsed between the date of the filing of the action and the date of satisfaction of the judgment or award at a rate equal to two percentage points above the 26-week U.S. Treasury Bill rate.

B. Interest on an award of damages rendered on a written instrument specifying a rate of interest shall be calculated for the period of time elapsed between the date of the filing of the action and the date of satisfaction of the final judgment or award at the rate specified in the instrument if that rate was lawful at the time the instrument was executed.

C. Interest on a judgment or award of damages rendered in a personal injury or wrongful death action shall be calculated at a rate equal to two percentage points about the 26-week U.S. Treasury Bill rate.

B. The rate of interest determined according to this Section shall be applicable to the award of both prejudgment and post-judgment interest.

C. Post-judgment interest shall be calculated for the period of time elapsed between the date of the final judgment and the date of satisfaction of the final judgment, provided that post-judgment interest shall not be calculated for the period of time elapsed during the prosecution of a post-judgment appeal initiated solely by the plaintiff.

D. Notwithstanding any other provision of this Section, prejudgment interest shall not be awarded for the 6 month period following the date of the injury or the accrual of the action, whichever is later.

E. The period of time for which prejudgment interest shall be awarded to the plaintiff shall begin to run as soon after the 6 month exception period as the plaintiff serves upon the defendant a written settlement demand, if and only if, that settlement demand is not more than 115 percent of the award of damages, provided that for purposes of this subsection the award of damages must have first been adjusted in accordance with any determination of comparative negligence, additur, remittitur, set-off or credit.

F. The period of time for which prejudgment interest shall be awarded to the plaintiff shall stop running, even if it never began to run, as soon after the 6 month limitation period as the defendant serves upon the plaintiff an offer of settlement, if and only if, that offer of settlement is not less than 85 percent of the award of the damages; provided that for purposes of this subsection the award of damages; provided that for purposes of this subsection the award of damages must have first been adjusted in accordance with any determination of comparative negligence, additur, remittitur, set-off or credit. Otherwise, the period of time for which prejudgment interest shall be awarded shall stop running on the date of the entry of the final judgment.

G. In order to determine the consequences of the plaintiff's demands and the defendant's offers of settlement following the delivery of the award of damages, all such demands and offers must be submitted, in writing, to the court prior to the delivery of the award of damages. Subsequent to the delivery of the award of damages and prior to the entry of the final judgment, the judge shall determine the award of prejudgment interest and include it within the final judgment in accordance with this Section. Interest shall be calculated only upon awards of damages that have been adjusted in accordance with any determination of comparative negligence, additur, remittitur, set-off or credit. Evidence of the demands or offers of settlement shall not be admissible except in a proceeding to determine awards of prejudgment interest.

H. All settlement demands of offers of settlement shall remain open for acceptance by the opposing party for at least 60 days.

I. This section does not require an award of prejudgment interest in a judgment arising from the acceptance of an offer to settle made under this Section.

J. Subsequent settlement demands or offers of settlement are permissible and shall have no effect, for the purposes of determining awards of prejudgment interest, upon the prior demands of offers of any party to the litigation.

K. Prejudgment interest shall be awarded for past economic damages only. Prejudgment interest shall not be awarded for past non-economic damages, punitive damages, or future damages.

L. Interest shall be calculated only upon awards of damages that have been adjusted in accordance with any determination of comparative negligence, additur, remittitur, set-off or credit.

M. In every civil action subject to an award of either prejudgment or post-judgment interest, the jury shall be instructed that both prejudgment and post-judgment interest will be added to the jury verdict in accordance with applicable state law. The jury shall be further instructed that additional awards of either prejudgment or post-judgment interest by the jury are expressly prohibited.

Section 18. Limitation of Punitive Damages.

(Drafting Note: An alternative to a hard cap can be found in ALEC's Constitutional Guidelines on Punitive Damages Act which put into statute the United States Supreme Court's guideposts for courts to follow in determining whether a punitive damages award is so "grossly excessive" that it furthers no legitimate purpose and constitutes an arbitrary deprivation of property in violation of the Due Process Clause of the Fourteenth Amendment.)

A. In all actions seeking an award of punitive damages, the trier of fact shall determine the amount of punitive damages separately from the amount of compensation for all other damages.

B. Punitive damages awarded against a defendant shall not exceed three times the amount of compensatory damages or two hundred fifty thousand dollars ($250,000), whichever is greater. If a trier of fact returns a verdict for punitive damages in excess of the maximum amount specified under this subsection, the trial court shall reduce the award and enter judgment for punitive damages in the maximum amount.

C. The provisions of Paragraph B of this Section shall not be made known to the trier of fact through any means, including voir dire, the introduction into evidence, argument, or instructions to the jury.

Section 19. Comparative and Contributory Negligence.

(Drafting Note: There are two alternatives to include in this Section. Paragraphs A1-N1 allows for a modified comparative negligence doctrine, meaning that the plaintiff's recovery is barred if his or her negligence exceeds the combined negligence of all defendants. Paragraph A2 allows for a pure form of comparative negligence, meaning that the plaintiff's award is reduced in proportion to his or her relative degree of fault. A court or jury would have discretion to bar the recovery if the plaintiff willfully or wantonly caused or contributed to the death or injury.)

A1. In causes of action based on negligence, contributory negligence shall not bar recovery in an action by any person or the person's legal representative to recover damages resulting from personal injury, wrongful death, or damage to the property if the negligence was not greater than the combined negligence of the person or persons against

whom recovery is sought including settled or released persons under this Section. The economic or noneconomic damages allowed shall be diminished in the proportion of the percentage of negligence attributable to the person recovering which percentage shall be determined by this Section.

B1. In a negligence action to recover damages resulting from personal injury, wrongful death or damage to property occurring on or after **{insert effective date}**, if the damages are determined to be proximately caused by the negligence of more than one party, each party against whom recovery is allowed shall be liable to the claimant only for such party's proportionate share of the recoverable economic damages and the recoverable noneconomic damages except as provided in this Section.

C1. The proportionate share of damages for which each party is liable is calculated by multiplying the recoverable economic damages and the recoverable noneconomic damages by a fraction in which the numerator is the party's percentage of negligence, which percentage shall be determined pursuant to this Section, and the denominator is the total of the percentages of negligence, which percentages shall be determined pursuant to this Section, to be attributable to all parties whose negligent actions were a proximate cause of the injury, death or damage to property including settled or released persons under this Section. Any percentage of negligence attributable to the claimant shall not be included in the denominator of the fraction.

D1. In any action to which this section is applicable, the instructions to the jury given by the court shall include an explanation of the effect on awards and liabilities of the percentage of negligence found by the jury to be attributable to each party.

E1. The jury or, if there is no jury, the court shall specify:

1. The amount of economic damages;

2. The amount of noneconomic damages;

3. Any findings of fact necessary for the court to specify recoverable economic damages and recoverable noneconomic damages;

4. The percentage of negligence that proximately caused the injury, death or damage to property in relation to one hundred per cent, that is attributable to each party whose negligent actions were a proximate cause of the injury, death or damage to property including settled or released persons under this Section; and

5. The percentage of such negligence attributable to the claimant.

F1.

1. Upon motion by the claimant to open the judgment filed, after good faith efforts by the claimant to collect from a liable defendant, not later than one year after judgment becomes final through lapse of time or through exhaustion of

appeal, whichever occurs later, the court shall determine whether all or part of a defendant's proportionate share of the recoverable economic damages and recoverable noneconomic damages is uncollectible from that party, and shall reallocate such uncollectible amount among the other defendants in accordance with the provisions of this Section.

2. The court shall order that the portion of such uncollectible amount which represents recoverable noneconomic damages be reallocated among the other defendants according to their percentages of negligence, provided that the court shall not reallocate to any such defendant an amount greater than that defendant's percentage of negligence multiplied by such uncollectible amount.

3. The court shall order that the portion of such uncollectible amount which represents recoverable economic damages be reallocated among the other defendants. The court shall reallocate to any such other defendant an amount equal to such uncollectible amount of recoverable economic damages multiplied by a fraction in which the numerator is such defendant's percentage of negligence and the denominator is the total of the percentages of negligence of all defendants, excluding any defendant whose liability is being reallocated.

4. The defendant whose liability is reallocated is nonetheless subject to contribution pursuant to this Section and to any continuing liability to the claimant on the judgment.

G1.

1. A right of contribution exists in parties who, pursuant to this Section are required to pay more than their proportionate share of such judgment. The total recovery by a party seeking contribution shall be limited to the amount paid by such party in excess of such party's proportionate share of such judgment.

2. An action for contribution shall be brought within two years after the party seeking contribution has made the final payment in excess of such party's proportionate share of the claim.

H1. This Section shall not limit or impair any right of subrogation arising from any other relationship.

I1. This Section shall not impair any right to indemnity under existing law. Where one tortfeasor is entitled to indemnity from another, the right of the indemnitee is for indemnity and not contribution, and the indemnitor is not entitled to contribution from the indemnitee for any portion of such indemnity obligation.

J1. This Section shall not apply to breaches of trust or of other fiduciary obligation.

K1. The legal doctrines of last clear chance and assumption of risk in actions to which this section is applicable are abolished.

L1. The family car doctrine shall not be applied to impute contributory or comparative negligence pursuant to this section to the owner of any motor vehicle or motor boat.

M1. A release, settlement or similar agreement entered into by a claimant and a person discharges that person from all liability for contribution, but it does not discharge any other persons liable upon the same claim unless it so provides. However, the total award of damages is reduced by the amount of the released person's percentage of negligence determined in accordance this Section.

N1. Except as provided in this Section, there shall be no apportionment of liability or damages between parties liable for negligence and parties liable on any basis other than negligence including, but not limited to, intentional, wanton or reckless misconduct, strict liability or liability pursuant to any cause of action created by statute, except that liability may be apportioned among parties liable for negligence in any cause of action created by statute based on negligence including, but not limited to, an action for wrongful death pursuant to **{insert section)** or an action for injuries caused by a motor vehicle owned by the state pursuant to **{insert section}**.

A2. The defense of contributory negligence or of assumption of risk is in all cases a question of fact and shall at all times be left to the jury. If the jury applies either defense, the claimant's action is not barred, but the full damages shall be reduced in proportion to the relative degree of the claimant's fault which is a proximate cause of the injury or death, if any. There is no right to comparative negligence in favor of any claimant who has intentionally, wilfully or wantonly caused or contributed to the injury or wrongful death.

B. The following definitions apply, as used in this Section:

1. "Economic damages" means compensation determined by the trier of fact for pecuniary losses including, but not limited to, the cost of reasonable and necessary medical care, rehabilitative services, custodial care and loss of earnings or earning capacity excluding any noneconomic damages.

2. "Noneconomic damages" means compensation determined by the trier of fact for all nonpecuniary losses including, but not limited to, physical pain and suffering and mental and emotional suffering.

3. "Recoverable economic damages" means the economic damages reduced by any applicable findings including but not limited to set-offs, credits, comparative negligence, additur and remittitur, and any reduction provided by **{insert section}**.

4. "Recoverable noneconomic damages" means the noneconomic damages reduced by any applicable findings including but not limited to set-offs, credits, comparative negligence, additur and remittitur.

5. "Claimant's fault" includes the fault imputed or attributed to a claimant by operation of law, if any.

Section 20. Ostensible Agency.

A. The total amount recoverable for an injury or death of a patient may not exceed the following:

1. Five hundred thousand dollars ($500,000) for an act of malpractice that occurs before **{insert date}**.

2. Seven hundred fifty thousand dollars ($750,000) for an act of malpractice that occurs:

a) after **{insert date}**, and

b) before **{insert date}**.

3. One million two hundred fifty thousand dollars ($1,250,000) for an act of malpractice that occurs after **{insert date}**.

B. A health care provider qualified under this article (or **{insert code section}** before its repeal) is not liable for an amount in excess of two hundred fifty thousand dollars ($250,000) for an occurrence of malpractice.

C. Any amount due from a judgment or settlement that is in excess of the total liability of all liable health care providers, subject to Paragraphs A, B, and D, shall be paid from the patient's compensation fund under **{insert code section}**.

(Drafting Note: There are two alternatives to this section. Paragraph D2 allows for a state's case and statutory law to be reviewed, to make sure that all theories in that jurisdiction for the imposition of vicarious liability are included in the bill language. In some states, other causes of action may exist that are not addressed under a theory of vicarious liability and this Act is not intended to address those other causes of action, such as breach of contract.)

D1. If a health care provider qualified under this article (or **{insert code section}** before its repeal) admits liability or is adjudicated liable solely by reason of the conduct of another health care provider who is an officer, agent, or employee of the health care provider acting in the course and scope of employment and qualified under this article (or **{insert code section}** before its repeal), the total amount that shall be paid to the claimant on behalf of the officer, agent, or employee and the health care provider by the health care provider or its insurer is two hundred fifty thousand dollars ($250,000). The balance

of an adjudicated amount to which the claimant is entitled shall be paid by other liable health care providers or the patient's compensation fund, or both.

D2. A health plan that has entered into a contract with a health care provider under which the health care provider delivers services to the health plan's enrollees as an independent contractor shall not be liable for the acts or omissions of the contracted health care provider, whether such claim is alleged under a theory of employer/employee, actual agency, ostensible agency or apparent agency or as a third-party beneficiary to the contract between the health plan and the health care provider.

Section 21. "I'm Sorry" Provision.

A. In any medical liability action, any and all statements, affirmations, gestures, or conduct expressing apology, sympathy, commiseration, condolence, compassion, fault, or a general sense of benevolence which are made by a health care provider or an employee of a health care provider to the plaintiff, a relative of the plaintiff, or a representative of the plaintiff and which relate solely to discomfort, pain, suffering, injury, or death as the result of the unanticipated outcome of the medical care shall be inadmissible as evidence of an admission of liability or as evidence of an admission against interest.

B. The following definitions apply, as used in this Section:

1. "Relative" means a spouse, parent, grandparent, stepfather, child, grandchild, brother, sister, half-brother, half-sister or spouse's parents. The term includes said relationships that are created as a result of adoption.

2. "Representative" means a legal guardian, attorney, person designated to make decisions on behalf of a patient under a durable power of attorney or health care proxy, or any person recognized in law or custom as an agent for the plaintiff.

3. "Gestures" are defined to include all statements, affirmations, gestures, or conduct by a health care provider or a provider's employee that express sympathy, condolence, and benevolence regarding pain, suffering, or death which follows an unanticipated medical care outcome.

Section 22. Right of Contribution.

A. The trier of fact, as to each cause of action asserted, shall determine the percentage of responsibility, stated in whole numbers, for the following persons with respect to each person's causing or contributing to cause in any way the harm for which recovery of damages is sought, whether by negligent act or omission, by any defective or unreasonably dangerous product, by other conduct or activity that violates an applicable legal standard, or by any combination of these:

1. Each claimant;

2. Each defendant;

3. Each settling person; and

4. Each responsible third party who has been designated under Section **{insert section}**.

B. This Section does not allow a submission to the jury of a question regarding conduct by any person without sufficient evidence to support the submission.

C. If a defendant who is jointly and severally liable under Section **{insert section}** pays a percentage of the damages for which the defendant is jointly and severally liable greater than his percentage of responsibility, that defendant has a right of contribution for the overpayment against each other liable defendant to the extent that the other liable defendant has not paid the percentage of the damages found by the trier of fact equal to that other defendant's percentage of responsibility.

D. As among themselves, each of the defendants who is jointly and severally liable under Section **{insert section}** is liable for the damages recoverable by the claimant under Section **{insert section}** in proportion to his respective percentage of responsibility. If a defendant who is jointly and severally liable pays a larger proportion of those damages than is required by his percentage of responsibility, that defendant has a right of contribution for the overpayment against each other defendant with whom he is jointly and severally liable under Section **{insert section}** to the extent that the other defendant has not paid the proportion of those damages required by that other defendant's percentage of responsibility.

E. If for any reason a liable defendant does not pay or contribute the portion of the damages required by his percentage of responsibility, the amount of the damages not paid or contributed by that defendant shall be paid or contributed by the remaining defendants who are jointly and severally liable for those damages. The additional amount to be paid or contributed by each of the defendants who is jointly and severally liable for those damages shall be in proportion to his respective percentage of responsibility.

F. No defendant has a right of contribution against any settling person.

Section 23. Burden of Proof.

The burden of proof in a medical negligence case is clear, cogent, and convincing evidence where the plaintiff has signed an informed consent form, but nonetheless alleges that she or he did not consent to medical treatment.

Section 24. Definitions.

As used in this Act or in any medical liability claim, the following are definitions for the terms "Claimant", "Health Care Goods or Services" and "Health Care Institution".

A. The term "Claimant" means any person who brings a health care lawsuit, including a person who asserts or claims a right to legal or equitable contribution, indemnity or subrogation, arising out of a health care liability claim or action, and any other person on

whose behalf such a claim is asserted or such an action is brought, whether deceased, incompetent, or a minor. All persons claiming to have sustained damages as a result of the bodily injury or death of a single person are considered a single claimant. All persons alleging a health care liability claim or action out of a single health care transaction or provision of professional or administrative services shall be considered one claimant.

B. The term "Health Care Goods or Services" means any goods or services provided by a health care institution, provider, or by any individual working under the supervision of a health care provider, that relates to the diagnosis, prevention, maintenance, care or treatment of any human disease, condition, or impairment, or the assessment, planning, or care of the health of human beings. This term is intended to cover all admissions in a health care institution, regardless of whether any individual admission or course of treatment involved the provision of professional or custodial care, or both.

C. The term "Health Care Institution" means any entity licensed under federal or state law to provide health care services, including but not limited to ambulatory surgical centers, assisted living facilities, emergency medical service providers, hospices, hospitals and hospital systems, nursing homes, or other entities licensed to provide such services. The term also includes: (1) an officer, director, shareholder, member, partner, manager, owner, affiliate, governing body, or member of the governing body of a health care institution, except "group health plans," "health insurance issuers," or "health maintenance organizations," as those terms are defined in 42 U.S.C. sections 300gg-91(a)-(b); and (2) an employee, independent contractor, or agent of a health care institution acting in the course and scope of the employment or contractual relationship.

Section 25. Health Care Providers, Including a Pharmacist and a Health Care Institution, Providing Volunteer Services, Including the Prescription of Medicine, without Compensation During a State of Emergency.

A. "State of Emergency" shall mean a catastrophic condition caused by any man-made event, natural event, or war-caused event resulting in substantial damage to property or the environment and injury or loss of life. The state of emergency can be declared by executive order.

B. No cause of action shall arise, and no judgment, damages, penalties, costs or other money entitlement shall be awarded or assessed, either directly, derivatively, or by way of contribution or indemnification, against any health care provider, including a pharmacist, or health care institution in any civil suit or proceeding at law or in equity, or before any administrative tribunal, for his or her decisions, acts, omissions in connections with the rendering of medical, pharmaceutical, hospital or dental care during a declared state of emergency.

C. The immunity shall commence upon the occurrence of the catastrophic condition which necessitates the declaration of a state of emergency or, in the case of an executive order until it expires or is lifted.

D. The immunity shall apply to health care providers and health care institutions, which provide their services without compensation for the sole purpose of responding to the declared state of emergency.

E. The immunity shall be absolute as to all civil claims or causes of action founded upon a decision, act or omission arising out of rendering medical or dental care during a declared state of emergency, except for an act during that time which constitutes an intentional, willful or wanton act unrelated to medical treatment. In any civil action or proceeding against a health care provider, including a pharmacist, or against a health care institution claiming immunity, the plaintiff shall have the burden of proving the absence of a declared state of emergency or that the decision, act, or omission complained of did not arise out of rendering medical or dental care during a declared state of emergency.

Section 26. Appeal from Interlocutory Order.

A. A person may appeal from an interlocutory order of a district court, county court of law, or county court that:

1. Appoints a receiver or trustee;

2. Overrules a motion to vacate an order that appoints a receiver or trustee;

3. Certifies or refuses to certify a class in a suit brought under **{insert appropriate state code and section}**;

4. Grants or refuses a temporary injunction or grants or overrules a motion to dissolve a temporary injunction;

5. Denies a motion for summary judgment that is based on an assertion of immunity of an individual who is an officer or employee of the state or a political subdivision of the state;

6. Denies a motion for summary judgment that is based in whole or in part upon a claim against or defense by a member of the electronic or print media, acting in such capacity, or a person whose communication appears in or is published by the electronic or print media, arising under the free speech or free press clause of the First Amendment to the United States Constitution, or **{insert appropriate article of the state constitution}**;

7. Grants or denies the special appearance of a defendant under the current rules of civil procedure, except in a suit brought under the **{insert the appropriate family code and section};**

8. Grants or denies a plea to the jurisdiction by a governmental unit that is defined under **{insert the appropriate code and section}**;

9. Denies all or part of the relief sought by a motion under the appropriate section of the civil practices and remedies code, except that an appeal may not be taken from an order granting an extension under **{insert appropriate code and section}**; or

10. Grants relief sought by a motion under **{insert appropriate code and section}**.

Section 27. Standards of Proof in Cases Involving Emergency Medical Care.
A. In a suit involving a health care liability claim against a physician or health care provider for injury to or death of a patient arising out of the provision of emergency medical care in a hospital emergency department or obstetrical unit or in a surgical suite immediately following the evaluation or treatment of a patient in a hospital emergency department, the claimant bringing the suit may prove that the treatment or lack of treatment by the physician or health care provider departed from accepted standards of medical care or health care only if the claimant shows by a preponderance of evidence that the physician or health care provider, with willful and wanton negligence, deviated from the degree of care and skill that is reasonably expected of an ordinarily prudent physician or health care provider in the same or similar circumstances.

Section 28. {Severability Clause}

Section 29. {Repealer Clause}

Section 30. Effective Date.
This Act will immediately become law upon signing of the governor.

Passed by the Health and Human Services Task Force on December 10, 2005.
Amended by the Health and Human Services Task Force on December 9, 2006.
Amended by the Health and Human Services Task Force on July 31, 2008.
Approved by the Board of Directors on September 11, 2008.

Mission Statement

To advance free markets, limited government, and federalism.